OVERSIGHT HEARING

BEFORE THE

SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH

OF THE

COMMITTEE ON THE DISTRICT OF COLUMBIA HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

EMERGENCY AMBULANCE SERVICE AND 911 EMERGENCY TELEPHONE SYSTEM

AUGUST 5, 1987

Serial No. 100-8

Printed for the use of the Committee on the District of Columbia

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STAFF SUMMARY OF FINDINGS AND CONCLUSIONS

Recent media accounts of the District of Columbia's emergency response system have given rise to many outside concerns. A good deal of media attention directed toward the District of Columbia's emergency response system has centered around the emergency ambulance service (911).

On August 5, 1987, the Fiscal Affairs and Health Subcommittee held an oversight hearing on Emergency Ambulance Service and 911. Testimony was received from Members of the U.S. House of Representatives and city officials of the District of Columbia.

In considering the question of the quality and the efficiency of the emergency response system in the District of Columbia, the subcommittee made every attempt to determine whether or not the District of Columbia's emergency system is different from or burdened by problems not found in other jurisdictions.

The lead witness, Mr. Thomas M. Downs, then city administrator and deputy mayor for operations of the District of Columbia, testified that nearly half of the calls received on the District's 911 number were of a nonemergency nature, and that this situation existed before the implementation of the 8DC-HELP system. (The 8DC-HELP system is an alternative number for nonemergency service.) If the 911 system receives a call that does not require the immediate dispatch of a police, fire or ambulance vehicle, the 911 operator transfers the call to "8DC-HELP". Similarly, if "8DC-HELP" receives a call that represents a true emergency, it will immediately transfer the call to 911. As far as can be ascertained, the District is the only jurisdiction in the Nation that has come up with a viable alternative number to 911 for citizens to call in nonemergency situations.

In June 1987, the District government's productivity management staff conducted a survey of the thirty (30) most populated U.S. cities, in addition to metropolitan area jurisdictions. The survey consisted of 21 detailed questions directed at response time, incident volume, resources, and operations. While not a scientific study on which definite resource allocations or operational decisions should be drawn, the study was sufficiently structured to allow comparison. The District ranked:

1.—9th among 29 cities in response time.

Ambulance response time has a variety of components that contribute to the time it takes to respond to an emergency medical situation. Most jurisdictions start the clock when the ambulance is dispatched and stop the clock when the ambulance arrives at the scene. For the purpose of this survey, response time refers to the time measured from dispatch to ambulance arrival on the scene.

2.—2d highest among 30 cities in the number of ambulance incidents per 10,000 population. D.C.'s rate of 1,649 incidents per 10,000 population was almost double the city average of 870 incidents. Only St. Louis ranked higher with a rate of 1,700.

It should also be noted that Washington metropolitan area jurisdictions showed a lower average number of incidents per 10,000 population when compared to major cities with an average rate of 679 versus 870 for cities surveyed.

3.—21st of 24 cities when comparing the ratio of call takers and dispatchers to incidents.

The average was .8 operators per 10,000 incidents which is more than double D.C.'s .3 operators. This has recently been approved with the hiring of fifteen (15) additional dispatchers.

OVERSIGHT HEARING ON EMERGENCY AMBULANCE SERVICE AND 911

WEDNESDAY, AUGUST 5, 1987

House of Representatives,
Subcommittee on Fiscal Affairs and Health,
Committee on the District of Columbia,
Washington, DC.

The subcommittee met, pursuant to call, at 10:12 a.m., in room 1310, Longworth House Office Building, Hon. Walter E. Fauntroy (chairman of the subcommittee) presiding.

Present: Representatives Fauntroy, Parris and Bliley.

Also present: Edward C. Sylvester, Jr., staff director; Johnny Barnes, senior staff counsel; Corliss Clemon and Margaret Gras, staff assistants; John Gnorski, minority staff director; Mark J. Robertson, Howard Lee, Jeff Schlagenhauf, and Shahid Z. Abdullah, minority staff assistants.

Mr. Fauntroy. The oversight hearing on emergency ambulance service in the District of Columbia before the Subcommittee on Fiscal Affairs and Health will come to order. We should all be concerned about quality, efficient emergency response service, and indeed we all are.

Among others, Members of Congress have expressed concern over recent media accounts of the District of Columbia's emergency response system. Our colleague from Virginia, Mr. Parris, has shown particular interest in the District's system, and has devoted time and energy to investigating the source of reported problems.

Indeed, this hearing today is due, in large part, to Mr. Parris' interest, and we certainly appreciate that. An emergency is an emergency, wherever it may occur. All of us care about the health, safety and well-being of every citizen in the Washington metropolitan area or in the Nation where this issue has become current in many, many communities. That is why we are here.

We're here because last summer in California a deaf woman died after her deaf husband's calls for help on a 911 emergency telephone system went unanswered. We are here because, according to a recent news report in the Washington Post, a Herndon resident in Fairfax County reported that she dialed 911 when she felt severe chest pains, but got no answer at all. After trying again, she dialed the operator and, when help arrived, she was told by rescue workers that about 10 other people had reported 911 problems.

We are here because in May of this year Nancy Clay, a 31-year-old resident of the State of Illinois, was trapped by fire on the 20th floor of an office building. She calmly dialed 911 and reported her

situation. She was told that help was on the way. She then called her father as the fire raged and, among other things, during their 90-second conversation she said to him, Daddy, I could die in here. Later when help had not arrived, she dialed 911 again and, according to the transcript of the call, she said, Somebody's got to find me before I die. She was not found in time. She died, apparently, because the fire department had trouble finding her.

We're here because Nancy Clay's death can only have meaning if we resolve that each of us will do all that we can to guard against a repeat of such a terrible tragedy.

Unfortunately, there are countless stories of failures of emergency systems across the country. An emergency is an emergency wherever it occurs. A good deal of media attention directed toward the District of Columbia's emergency response system has centered around the emergency ambulance service.

I think we should be candid and point out that many of the critics of the District's emergency ambulance service would have us believe that the requirement that emergency technicians live in the District is at the heart of the problem. Those critics should first be reminded that local government residency laws are not unusual. A 1980 survey of 49 cities with a population over 250,000 found 42 of those 49 cities with some sort of enforced residency requirements and a 1985 survey by the District government of jurisdictions similar to the District found that 68 percent had residency requirements.

Those critics should also be reminded, and the courts have long recognized, that community identity is indeed an important by-product of residency requirements, and that it enhances emergency service capability rather than detracts from it.

Moreover, those critics should be reminded that a Virginia or a Maryland resident would have more difficulty rather than less difficulty in locating an emergency as a driver or a dispatcher in the District of Columbia than a resident of the District would have.

This oversight hearing can contribute to a solution, or it can contribute to the problem of emergency medical service in the District of Columbia. It can contribute to the solution if we offer constructive responses to the real barriers confronting the District emergency service system.

This hearing will contribute to the problem if we target the District for criticism for reasons which go beyond its systems. I trust that we will all keep the memory of Nancy Clay in our minds. An emergency is an emergency wherever it occurs.

Before we go to the very exhaustive list of witnesses which we have for this hearing today, I want to yield to my distinguished colleague, Mr. Bliley, then to Mr. Parris.

[The prepared opening statement of Mr. Fauntroy follows:]

OPENING STATEMENT OF CONGRESSMAN WALTER E. FAUNTROY
DURING THE OVERSIGHT HEARING ON EMERGENCY AMBULANCE SERVICE
BEFORE THE SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH
OF THE HOUSE COMMITTEE ON THE DISTRICT OF COLUMBIA

AUGUST 5, 1987

WE SHOULD ALL BE CONCERNED ABOUT QUALITY, EFFICIENT EMERGENCY RESPONSE SYSTEMS, AND WE ARE.

AMONG OTHERS, MEMBERS OF CONGRESS HAVE EXPRESSED CONCERN OVER RECENT MEDIA ACCOUNTS OF THE DISTRICT OF COLUMBIA'S EMERGENCY RESPONSE SYSTEM. OUR COLLEAGUE FROM VIRGINIA, MR. PARRIS, HAS SHOWN PARTICULAR INTEREST IN THE DISTRICT'S SYSTEM AND HAS DEVOTED TIME AND ENERGY TO INVESTIGATING THE SOURCE OF THE REPORTED PROBLEMS.

INDEED, THIS HEARING TODAY IS DUE IN LARGE PART TO MR. PARRIS' INTEREST, AND WE APPRECIATE THAT. AN EMERGENCY IS AN EMERGENCY WHEREVER IT OCCURS. ALL OF US CARE ABOUT THE HEALTH, SAFETY AND WELL-BEING OF ANY CITIZEN IN THE WASHINGTON METROPOLITAN AREA OR IN THE NATION. AND THAT IS WHY WE ARE HERE.

WE ARE HERE BECAUSE LAST SUMMER IN CALIFORNIA A DEAF WOMAN DIED AFTER HER DEAF HUSBAND'S CALLS FOR HELP ON A 911 EMERGENCY TELEPHONE SYSTEM WENT UNANSWERED. WE ARE HERE BECAUSE, ACCORDING TO A RECENT NEWS REPORT IN THE WASHINGTON POST, A HERNDON RESIDENT IN FAIRFAX COUNTY REPORTED THAT SHE DIALED 911 WHEN SHE FELT SEVERE CHEST PAINS, BUT "NO ONE ANSWERED THE PHONE." AFTER TRYING AGAIN, SHE DIALED THE OPERATOR AND WHEN HELP ARRIVED SHE WAS TOLD BY RESCUE WORKERS THAT ABOUT 10 OTHER

PEOPLE HAD REPORTED 911 PROBLEMS.

WE ARE HERE BECAUSE IN MAY OF THIS YEAR, NANCY CLAY, A 31 YEAR OLD RESIDENT OF THE STATE OF ILLINOIS WAS TRAPPED BY FIRE ON THE 20TH FLOOR OF AN OFFICE BUILDING. SHE CALMLY DIALED 911 AND REPORTED HER SITUATION. SHE WAS TOLD THAT HELP WAS ON THE WAY. SHE THEN CALLED HER FATHER, AS THE FIRE RAGED, AND AMONG OTHER THINGS DURING THEIR 90-SECOND CONVERSATION, SHE SAID TO HIM, "DAD, I COULD DIE IN HERE." LATER, WHEN HELP HAD NOT ARRIVED, SHE DIALED 911 AGAIN, AND ACCORDING TO THE TRANSCRIPT OF THE CALL, SHE SAID, "SOMEBODY'S GOT TO FIND ME BEFORE I DIE!"

SHE WAS NOT FOUND IN TIME. SHE DIED APPARENTLY BECAUSE THE FIRE DEPARTMENT HAD TROUBLE FINDING HER.

WE ARE HERE BECAUSE NANCY CLAY'S DEATH CAN ONLY HAVE MEANING IF WE RESOLVE THAT EACH OF US WILL DO ALL THAT WE CAN TO GUARD AGAINST A REPEAT OF SUCH A TERRIBLE TRAGEDY. UNFORTUNATELY, THERE ARE COUNTLESS STORIES OF FAILURES OF EMERGENCY SYSTEMS ACROSS THE COUNTRY. AN EMERGENCY IS AN EMERGENCY WHEREVER IT OCCURS.

A GOOD DEAL OF THE MEDIA ATTENTION DIRECTED TOWARDS THE DISTRICT OF COLUMBIA'S EMERGENCY RESPONSE SYSTEM HAS CENTERED AROUND THE EMERGENCY AMBULANCE SERVICE.

I THINK WE SHOULD BE CANDID AND POINT OUT THAT MANY OF THE CRITICS OF THE DISTRICT'S EMERGENCY AMBULANCE SERVICE WOULD HAVE US BELIEVE THAT THE REQUIREMENT THAT EMERGENCY TECHNICIANS LIVE IN THE DISTRICT IS AT

THE HEART OF THE PROBLEM.

THOSE CRITICS SHOULD FIRST BE REMINDED THAT LOCAL GOVERNMENT RESIDENCY LAWS ARE NOT UNUSUAL. A 1980 SURVEY OF 49 CITIES WITH A POPULATION OVER 250,000 FOUND 42 OF THESE CITIES WITH SOME SORT OF ENFORCED RESIDENCY REQUIREMENT. AND A 1985 SURVEY BY THE DISTRICT GOVERNMENT OF JURISDICTIONS SIMILAR TO THE DISTRICT, FOUND THAT 68 PERCENT HAD RESIDENCY REQUIREMENTS.

THOSE CRITICS SHOULD ALSO BE REMINDED AND THE COURTS HAVE LONG RECOGNIZED THAT "COMMUNITY IDENTITY," AN IMPORTANT BY-PRODUCT OF RESIDENCY REQUIREMENTS, ENHANCES EMERGENCY SERVICE CAPABILITY RATHER THAN DETRACTS FROM IT.

MOREOVER THOSE CRITICS SHOULD BE REMINDED THAT A VIRGINIA OR MARYLAND RESIDENT WOULD HAVE MORE DIFFICULTY RATHER THAN LESS IN LOCATING AN EMERGENCY AS A DRIVER OR DISPATCHER IN THE DISTRICT OF COLUMBIA THAN A RESIDENT OF THE DISTRICT WOULD HAVE.

THIS OVERSIGHT HEARING CAN CONTRIBUTE TO THE SOLUTION OR IT CAN CONTRIBUTE TO THE PROBLEM OF EMERGENCY MEDICAL SERVICE IN THE DISTRICT OF COLUMBIA.

IT CAN CONTRIBUTE TO THE SOLUTION IF WE OFFER CONSTRUCTIVE RESPONSES TO THE REAL BARRIERS CONFRONTING THE DISTRICT'S EMERGENCY SERVICE SYSTEM. THIS HEARING WILL CONTRIBUTE TO THE PROBLEM IF WE TARGET THE DISTRICT FOR CRITICISM FOR REASONS WHICH GO BEYOND ITS SYSTEMS.

I TRUST WE WILL ALL KEEP THE MEMORY OF NANCY CLAY IN OUR MINDS. AN EMERGENCY IS AN EMERGENCY WHEREVER IT OCCURS.

Mr. BLILEY. Thank you, Mr. Chairman. I don't have a prepared statement. I would, however, like to make just a couple of brief points.

The city suffers from a crisis of confidence. I'm not as concerned over the Congress' lack of confidence as I am that of the citizens of the District of Columbia. Mr. Chairman, I commit myself to working with you to restore the confidence of the citizens of this city in their emergency services.

I thank the Chairman for yielding.

Mr. FAUNTROY. And I thank the gentleman. Mr. Parris.

Mr. PARRIS. Thank you, Mr. Chairman. First let me once again apologize for being tardy to this hearing. We had a conference on the floor in regard to the negotiated settlement of the conflict in Central America which is a very promising, certainly of critical importance.

I have a brief statement, Mr. Chairman, which I would like to state in the record; and I appreciate the opportunity to do so. I am especially grateful to my colleague and friend from Virginia, Mr. Bliley, for his leadership on this issue generally.

Let me, Mr. Chairman, very quickly run through this statement, and I would ask unanimous consent that the entire statement be included in the record.

Mr. FAUNTROY. Without objection.

Mr. PARRIS. I have requested, Mr. Chairman, that a number of professionals and experts from all facets of the city's emergency service system appear before the subcommittee today, along with Mr. Bliley, as I just indicated, so that we might get a clear reading of where the system has been, where we are today, perhaps where we're going for what all of us hope will be more efficiency and a better service to all of our constituents in the future.

It's my hope that this exercise will be more than a little helpful in the solution in providing some guidance to the problems that the city has experienced over these last few weeks and months. Perhaps we can make some constructive and substantive changes in the EMS system, which is the purpose that we're all here.

Inadequacies in the current operation are, in my judgment, self-evident. These problems have received a great deal of attention in the local and even in the national media, and some might ask why. Why all this attention? Why is the national and international media so interested in what is going on in this little city of ours?

The answer is obvious and self-evident. This is the Nation's Capital. It's not just another typical metropolitan area. There's literally hundreds of thousands of American and foreign tourists of all kinds every year, and the site of the principal embassies of every nation in the world, et cetera. In short, the residents of this city are not the only ones with a vested interest in having an efficient and effective emergency medical service in the District of Columbia. That's the fundamental reason why these hearings are being held.

I am not going into this hearing ignorant of the facts or of the current system. A great deal of time has been dedicated to this matter by persons in my office, my staff, with some immodesty, to some degree myself, recently spent some time riding with a medi-

cal unit in No. 9 in southeast Washington, an interesting experience; not very pleasant, but interesting and enlightening.

A member of my staff has spent 20 hours riding with the ambulance and medic units in virtually every area of this city, and some of those experiences, I think, have been very enlightening.

Now while I believe strongly that these hearings will be successful in producing some constructive ideas on how to improve the EMS, I'm even more concerned, Mr. Chairman, that they may fall on deaf ears in the city; and there's a good cause, I think, for that concern.

I have had the opportunity to review the report of Dr. Ehrlich, Frank E. Ehrlich, a recognized EMS expert who has inspected over 50 trauma centers and EMS systems. Dr. Ehrlich was asked to review the District's system by the city's commissioner of public health, to his credit, Dr. Andrew McBride. We have a copy of Dr. Ehrlich's report here dated May 30, 1986, 14, 15 months ago; and I am told that, fundamentally, no action has been taken on any of the recommendations contained in that report, 15 months later.

I also have here in front of us a copy of the July 1986 report and recommendation of Mayor Barry's EMS advisory committee. That report is highly critical of the current EMS system—the way in which it was being managed by the city.

My point in all of this is that those two reports were very comprehensive and constructive. Expert preparation went into much of them. The studies were conducted by highly respected authorities in the field. Both of these critical reports have been all but ignored in their implementation by the city. Once again, this is the reason for these hearings.

The result and the recommendations, if any, if they can be constructive and helpful, will not be ignored. I want to point out that we are not here to dictate what should be done or to suggest how it should be done, but to try to insist that something must be done.

At this point I would ask, Mr. Chairman, that both of these reports be inserted into the record in their entirety, and take just another few moments, if I might to discuss some of those findings. Then we'll get into the substance during the question and answer period of these hearings.

Mr. FAUNTROY. Without objection, so ordered.

Mr. PARRIS. Thank you, Mr. Chairman.

[The attachments to Mr. Parris' statement follow:]

Instituted 1855

Instituted 1895

The Buffalo General Hospital

a health care system including the Deaconess Hospital of Buffalo
A Primary Affiliate of the Faculty of Health Sciences
State University of New York at Buffalo

Associate Professor of Surgery
Head, Division of Emergency Services
Dept. of Surgery, SUNYAB

FRANK E. EHRLICH, M.D., F.A.C.S., F.A.C.E.P.
100 High Street Buffalo, New York 14203

Head of Department of Emergency Medicine
and Trauma Services
Buffalo General Hospital

NATIONALLY RECOGNIZED EMS EXPERT

May 30, 1986

Andrew D. McBride, M.D., M.P.H.
Commission of Public Health
Office Emergency Health & Medical Services
1875 Connecticut N.W.
Room 825
Washington, D.C. 20009

Sir:

At the orientation dinner Dr. Wolferth and I were asked to render our opinions on the current EMS and trauma system in the District of Columbia. I feel the request was predicated on my experience with over 50 trauma center inspections and intimate knowledge of the EMS systems in which those trauma centers exist. In addition, EMS is a long standing interest of mine and lies within the domain of my specialties.

I should like to provide my observations as a simplified list and ask that you consider them not in any specific rank or order.

1. My first comment concerns the format for your inspection process. While I think the inspections were carried out without prejudice or bias on the part of your local inspectors, I would suggest that future inspections be done by a team from outside the District and the area it serves. I feel strongly that if a hospital was dissatisfied with the results of our inspections, and claimed "foul ball" in a court of law, it would be unlikely that a judge would rule in your favor. Capricious and prejudicial behavior on the part of an inspector may be difficult to prove, but the image and doubt thus created are even more difficult to defend. In order to gusrantee that your process leads to a viable system, I would do nothing to jeopardize its development. Out of state inspectors would eliminate thia concern. In other areas, where I have consulted, inspectors have been hired from outside the geogrephic aree and the cost for those inspectors has been transferred directly to the hospital by way of an inspection fee. This is fairly routine and as an added benefit eliminates this expense from the local government EMS budget.

2. I would recommend for the future, that your inspection team contain a recognized trauma surgeon, a recognized emergency medicine physician familiar with trauma systems and emergency medical systems, a neurosurgeon familiar with trauma care, a trauma nurse coordinator or a nurse specialist in the trauma field, and finally a hospital administrator familiar with trauma centers. This combination has provided the broadest insight into the ability of a given institution to perform as a trauma center.

3. There needs to be a significant strengthening of your EMS system. Given that your system is under governmental control, it should be much stronger,with better quality control,producing better results. For example, you are lacking perhaps the most important feature of a good EMS system and that is proper medical control for the system. You need a strong, energetic physician well schooled in emergency medical services to take over and run your EMS system. For the day to day system management this should become literally a dictatorship. It would be appropriate to have a committee, such as now exists, lending support and advice to this individual on matters of policy development. In general,medical command and supervision is weak and needs to be strengthened. Without medical control, no EMS system can achieve the necessary level of function to adequately serve its community.

4. There needs to be better auditing of the ambulance run sheets, medical command provided by hospitals and of outcome data. In particular, all ALS runs should be scrutinized for these areas. This data can then be passed from your medical director to your EMS committee for final disposition.

5. Medical command hospitals should be designated (the number probably doesn't matter if supervision is adequate) and all physicians' working in those institutions should be qualified by a set of regulations. You could include in the aforementioned audit the actual recorded tapes of the command process.

6. There is a dramatic need for better control of BLS services. Often times it is in the BLS community that trauma takes its biggest beating. Audit and review of BLS records, particularly in the situation of trauma

patients and/or patients who on scrutiny by a medical command physician are in critical condition, should be done on a regular basis.

7. There needs to be better usage of the helicopter within the District of Columbia. It is obvious in the early morning and evening rush hours that land transportation to and from an accident or cardiac arrest can take a prolonged period of time. The unfortunate situation is that the cardiac arrest can often go to the nearest emergency department and receive first class treatment. This may not be the same for trauma, (particularly after you put your trauma system in place). Patients should be in position to bypass the nearest hospital and go to that facility which has been recognized for its capability to deliver IMMEDIATE trauma care. The problem is when the ambulance can't get to that facility, we have an inflow obstruction to good trauma care. There are many ways to make use of the helicopter within a community (ball fields, parking lots, roof tops, etc,). A secondary system for evacuation of patients needs to be developed and used.

8. While I realize that this may be difficult to achieve, I would strongly recommend that you request a waiver for the local residency rule as applied to paramedics. This regulation with all of its good intent will only hinder the development of your EMS program. Paramedics are not the same as fire fighters and policemen. I do not mean that in a derogatory way but it takes a very special person to be a paramedic and while special characteristics are required of firemen and policemen, I think the scope of applicants is much smaller for the paramedic group. I would therefore, suggest that your current residency rule restricts your list of applicants to the point where you are depriving yourselves of the most qualified individuals.

In summary, I would like to state that I think most, if not all of the elements for a good trauma system are in place. You need however, to have a strong and KNOWLEDGEABLE physician head up your EMS system so as to bring it together as a cohesive, organized, and fully functional unit. If I were to site an example, I would refer you to Dr. Ron Stewart in Pittsburgh who along with Glenn Cannon has made the City of Pittsburgh Fire Department Paramedic Service one of the finest in the world. With such individuals in place, the only other feature needed

will be the unyielding support of your office. You will have to go to "the mats" for these individuals politically and give them the necessary freedom to fully develop the system's potential. Your office is a major key to the success of the EMS system, without your support and assistance they will have no chance.

I think you will need to respond to many of my suggestions if you desire a first class EMS system. Once that is achieved you will be able to hopefully claim a first class trauma system. Trauma is a single component of EMS and until your EMS system is a well oiled machine, your trauma system will be no better.

If I can be of further assistance as regards any of these issues or future trauma system developments, please do not hesitate to call upon me.

Sincerely yours,

Frank Ehrlich

Frank Ehrlich, M.D.

cc: Howard Champion
Mary Berkeley

EMSAC TASK FORCE REPORT Preliminary Findings

EMS Advisory Committee MAY 1986

The task force was given the responsibility of evaluating the EMS System and the prehospital care rendered in the District of Columbia. All aspects of the system were looked at in an effort to find the strengths and weaknesses. Using a format well documented in the literature, the task force evaluated the following areas Quality Assurance, Training, Personnel issues, Supervision, Staffing patterns, Communication, and Administration. In all areas we found reason for grave concern. The problems are multiple and complex. No area is without significant problems for example:

1. Quality Assurance:
   a. There is no evidence of consistent or meaningful audit at either the ALS or BLS levels.
   b. No fixed criteria was found for quality assurance.

2. Training:
   a. At least 42% of all ambulance personnel ie. EMT, IP, P, do not have current C.P.R. cards.
   b. Of the 1494 F/F in the DCFD, only 34 have current EMT certicfication, none have 1st responder, and 90-100% lack C.P.R. certicfication.

3. Selection for Upgrade:
   a. Of the 60 EMT is tested to upgrade to the IP level, the average written score was 79.7 and the average practical score was 64.6 (which is well below the national minimum skill level).
   b. No documention was available to substantiate the practical scores.

4. Personnel Issues:
   a. The pool of incoming applicants is restricted most likely by the residency requirement.
   b. Applicants are being accepted with no prior medical experience and there has been no adaptation to the initial training phase to accomodate this issue.

5. Supervision:
   a. In-field supervision at all levels is inadequate to appropriately monitor the medical care delivered.
   b. There is no in-field evaluation at EMT level.
   c. Evaluation at IP & P level's sporadic and inconsistant.
   d. Record review appears non-existant.
   e. No fixed criteria found for selection to supervisory positions or for in-field evaluators.

6. Staffing Patterns:
   a. Excessive amounts of overtime noted.
   b. Working 24^{0} at a time is routine.
   c. Can be ordered to work to keep units in service.

7. Administrative:
    a. Run Forms show inadequate documenation of VS, therapies, and narrative.
    b. Chain of command is confusing.
    c. Record keeping is poor in all areas.

These examples denote the tip of the iceberg. There is no quick-fix here. The task force has by no means finished its evaluation process. We have further documents in our posession from within the Department which must be looked at carefully and digested before comment can be made.

We are in receipt of comments made by the Consultant Trauma team inspectors, Dr. Wolferth & Erlich, which also outline areas of concern from their perspective in regards to the EMS system and the quality of care in the District of Columbia. Most notably these reference the following areas:

1. Needs significant strengthening of the system as a whole.
2. Medical command supervision is weak.
3. Lack of proper medical control.
4. Better auditing of ambulance run sheets and of outcome data.
5. Better control of BLS services.
6. Audit and review of BLS records.
7. Would strongly recommend waiving the residency requirements.

It is our hope that by the July meeting we will be prepared to submit a final report as well as our suggestions for solving some of the inherent problems.

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FINAL
REPORT
JULY 1986

Introduction

During the April meeting of the Emergency Medical Services Advisory Committee (EMSAC) a letter expressing deep concern regarding the training and performance of D.C. Fire Department prehospital providers was read. The letter was signed by representatives of the four hospitals which were engaged in training a group of basic providers to the intermediate paramedic level. The concerns were based upon:

1. the disappointing level of performance of the class members.

2. conversations within the consortium group that evidenced incidents of poor prehospital care.

The EMS Task Group was appointed by the Emergency Medical Services Advisory Committee. The Task Group was given the responsibility of evaluating the EMS System and the prehospital care rendered in the District of Columbia. An additional issue was to determine the advisability of continuing with plans for advanced programs such as EMT-Defibrillation and EMT/P Endotrachael intubation. An interim report was presented to the parent committee in June. The following material is presented as the final report of the Task Group.

The Task Group consisted of the following:

Harry Chen, M.D.	George Washington University (Chairman)
Horace Lasiter, M.D.	Howard University Hospital
Midge Moreau, R.N.	Washington Hospital Center
Sue Brown, M.S.W.	Commission of Public Health
Lt. Stankovich	D.C. Fire Department
D.F.C. Ray Alfred (replaced Lt. Stankovich)	D.C. Fire Department
Sherry Adams, R.N.	George Washington University
Bob Meehan	EMS Advisory Committee

In order to formulate a reasonable evaluation process, members of the Task Group researched available literature on the evaluation process used in other systems. The majority of literature related to all ALS systems and was not wholly applicable to the D.C. system. However, an attempt was made to identify the common points and adopt a suitable process of evaluation for D.C. The following areas were identified and used in this evaluation process:

1. Selection Process
2. Quality Assessment/Assurance
3. Training
4. Infield Medical Supervision
5. Staffing patterns
6. Communication
7. Organizational Structure
8. Medical Control
9. System Abuse
10. Equipment

The evaluation was divided into three phases - information accumulation, problem identification, and formulation of recommendations.

For the first two phases the Task Group met with a number of people and requested numerous documents from the D.C. Fire Department and other sources. Anecdotal information was accepted, especially if no other documentation was known to exist but this report relies most heavily on available documentation. The scope of the task made it necessary to limit the numbers and types of inquiries.

It is appropriate to note that the Task Group received a great deal of cooperation from numerous individuals and that such cooperation was greatly appreciated. The Task Group embarked upon the evaluation process as a positive action directed at trying to improve the existing system. The evaluation process and recommendations were designed with a "patient driven" system as the model; that is, a system designed and dedicated to meeting the needs of the patient.

It is also appropriate to note that since the formation of the Task Group, considerable activity has occurred within the Fire Department. It is apparent that some efforts are being made to initiate corrective measures prior to the presentation of this report. While rapid corrective action is a laudable goal, it is incumbent upon the EMSAC to ensure that such actions are in concert with the ultimate goal of creating a system which meets the needs of the patient and which will engender the support and commitment of the medical community.

The final report as it is presented is the result of the joint efforts of the Task Group members and represents a consensus of opinion unless otherwise noted in the body of the report.

The report is in a format which will hopefully enable the reviewer to study it in an organized fashion without requiring an inordinate amount of time. Included in the report is an executive summary and recommendation list for quick perusal.

Executive Summary

I. **Training**

- Firefighters respond 15,000 times annually for medical emergencies.
- Firefighters routinely cancel responses from incoming medical units.
- 100% of the firefighters (1494) do not have current CPR certification.
- 100% of the firefighters do not have current 1st responder training.
- 98% of the firefighters do not have EMT certification.
- 42% of EAD personnel checked (50) do not have current CPR certification.
- Training academy record keeping is inadequate, inaccurate and inefficient, i.e., CPR, CME, and EMT recertification records.
- No CME directed at basic skills.
- Inappropriate CME credit awarded, i.e., credit given for being a victim and/or evaluator during testing.
- Recertification training is allowed without documentation of the required number of CME hours.
- Recertification training is allowed even if all CME hours are obtained in the month prior to such training.
- No approved criteria for instructor selection.
- No formalized instructor courses.
- No formalized instructor evaluation process.
- No stability of instructor staff.
- Inadequate ancillary staff.
- No fixed schedule for all instructors to obtain adequate "street time."
- Inadequate inventory of equipment, supplies, and teaching aids.

Recommendations

1. Focus the efforts of the EAD Training Academy on upgrading all current personnel to appropriate standards before admitting any new EMT trainees.

2. Hold any new programs such as EMT-D training until such time as all current EAD personnel meet the minimum AHA and DOT standards.

3. Continue upgrade training from EMT to IP or IP to P level as well as endotracheal intubation training at the P level as long as there is a built in mechanism to review basic skills during the upgrade.

4. Ensure that on Priority M incidents that the firefighting units do not cancel incoming medical units unless no patient was found and that proper documentation is made.

5. Develop a plan within 30 days to recertify all Firefighters in CPR and ensure annual recertification.

6. Ensure the support of the medical community for the provision of resources for the initial CPR recertification program.

7. Ensure that all Firefighters currently assigned to Rescue Squads or who will in future be assigned to Rescue Squads be EMT trained, certified, and recertified as required.

Training Recommendations, Cont.

8. Train all Firefighters currently assigned to Engine Companies, Truck Companies and the fire boat to 1st responder level.

9. Recertify all EMT's in CPR within 30 days of the final report and ensure annual recertification.

10. Ensure the support of the medical community for the provision of resources for the initial CPR recertification program.

11. Ensure that EMT curriculum is suitable to the level of medical experience of entry level trainees. (see Selection Process)

12. Revise the current EMT recertification program to obtain the following:

    A. put all EMT's on quarterly schedule for recertification as is done with IP's and P's.

    B. require attendance at the recertification classes.

    C. require appropriate CME prior to recertification class, i.e., 12 hours annually.

    D. ensure that individuals whose certification has lapsed are not allowed to return to ambulance duty until certification has been reinstated.

13. Expand the Paramedic Review Board to include the certification, recertification, and decertification of EMT's.

14. Ensure that EMT continuing medical education:

    A. be appropriate to BLS provider.

    B. includes skill performance assessment and review.

    C. gives credit only for appropriate didactic and skill performance, i.e., not for participating as a victim or evaluator during testing situations.

    D. institutes pre and post testing for each session.

15. Revise the current ALS recertification program to obtain:

    A. recertification in CPR within 30 days of final report and annual recertification.

    B. ensure the support of the medical community for the provision of resources for the initial CPR recertification program.

    C. recertification to ACLS biannually.

    D. recertification at EMT level for all EMT/IP's biannually.

Training Recommendations, Cont.

16. Reorganize ALS CME to include:

    A. practical skills at:

        1) basic level
        2) advanced level

    B. credit be given only for appropriate activities.

    C. pre and post testing for each session.

    D. CME divided 50% per year.

Training Issues

1. Training Academy

    A. Evaluation of course material - revise as appropriate.

    B. Record keeping

        - computerize with local print capability
        - increase ancillary staff to adequately handle paperwork
        - establish adequate filing system

    C. Equipment

        - videotaping capability
        - update A-V equipment
        - update training aides
        - update training library with slides, tapes, books, etc.

2. Instructors

    A. devise appropriate selection process.

    B. develop written instructor training program.

    C. develop written instructor monitor/evaluation process.

    D. increase instructor staff to at least 10 full time from both ALS and BLS levels.

    E. ensure a fixed schedule to allow adequate "street time" for instructors.

Executive Summary

II. Quality Assessment/Assurance

- Run sheet review shows inadequate documentation, i.e.,

  42% of BLS sheets had no documentation of infield therapies
  48% of BLS sheets had only one set of vital signs and 30% of these had no time documented
  40% of BLS sheets had narrative reports inadequate to document patient assessment or care

- No infield evaluation process at the basic level (EMT).
- No supervised transition from school to field.
- No re-evaluation subsequent to the OJT period.
- Sporadic and inconsistent infield evaluation at the ALS level (IP, P).
- No fixed criteria noted for selecting or training DCFD field evaluators.
- Inadequate training of new protocols and equipment prior to field use.
- No evidence of systematic audit of run sheets at either the ALS and none at the BLS level.
- No written criteria for quality assurance was found.
- No process to monitor the medical care given by firefighters.
- No process to monitor/evaluate patient outcome.

Recommendations

1. Develop and ensure a system of quality assurance within the EAD under the guidance of the Commissioner of Public Health in cooperation with EMSAC.*

   The Medical Officer's performance in the area of quality assurance should be reviewed by an appropriate medical professional(s) selected by the Fire Chief in consultation with the Commissioner of Public Health.**

2. EMT-IP-P

   A. develop an on-going documented infield evaluation process reviewed by appropriate medical personnel.

      field evaluations to occur:

      1) during OJT
      2) twice annually (minimum)

   B. develop criteria to implement a system for consistent and on-going audit of run sheets.

   C. develop a set of criteria for skill performance.

   D. develop a set of criteria for selection and training of evaluators.

Quality Assurance/Assessment Recommendations, Cont.

E. develop an organized system by which field evaluators are monitored.

F. develop an organized remedial training program.

G. ensure annual CPR recertification.

3. Firefighters

A. ensure CPR recertification annually.

B. ensure on-going monitoring of medical activities.

C. ensure appropriate levels of training.

D. ensure the availability of appropriate equipment to render aid at all levels.

4. Develop a process for the collection and analysis of patient outcome data in cooperation with the medical community.

*Note: DFC Alfred and S. Brown dissent regarding the inclusion of EMSAC.
**Note: M. Moreau dissents regarding selection of medical professional by Fire Chief.
**Note: S. Adams dissents regarding the lack of involvement by EMSAC.

III. Medical Control

* Off-line (medical officer)

- Lack of review and evaluation of medical officer's performance by qualified medical professionals, there is no medical accountability at this time.
- No documentation of daily audit of run sheets.
- No clear cut chain of command.
- Lack of active participation at training academy.
- No fixed procedure for handling complaints lodged regarding medical issues.
- Inadequate supervision of and participation in infield evaluation process.
- Inadequate supervision of and participation in quality assurance.
- Inadequate official dissimination of information needed by system hospitals, i.e., new policies, procedures, and protocols.
- Lack of rapport with the medical community as well as the rank and file of EAD.

* On-line (base station)

- Inadequate quality assessment and assurance of both the tapes and written logs at base stations.
- Inadequate assurance of credentials of base station physicians.
- Inadequate number of standard base station courses.

Recommendations

Medical Control (off-line)

1. Ensure the presence of a strong, knowledgeable Medical Officer capable of acquiring the support and cooperation of a) the medical community, b) the prehospital provider, and c) the Fire Department administration.

2. Ensure that the qualifications of the Medical Officer include the following:

   A. physician, nurse, or physician assistant.

   B. knowledgeable and experienced in prehospital care.

   C. experienced in education, personnel supervision, and administrative skills.

3. Review, supervision, and evaluation of the Medical Officer's performance.

   A. by appropriate persons within the Fire Department.

   B. by appropriate medical professional/professionals outside the Department.

Medical Control Recommendations, Cont.

Medical Control (off line), Cont.

4. Clarify the chain of command and scope of authority of the Medical Officer regarding:

   A. daily audit of run sheets.

   B. supervision and direction of all training to ensure standards are met.

   C. provision of close supervision of all infield evaluations.

   D. liaison between EAD and all area hospitals and medical community.

   E. responsibility for evaluation of complaints relating to medical issues and reporting to appropriate regulatory agency.

   F. timely development, revision, and implementation of protocols in cooperation with medical community.

   G. day to day supervision over the shift supervisory staff.

5. Provide adequate ancillary personnel to accomplish tasks.

Medical Control (on-line Base Station)

1. Require ACLS certification.

2. Require standardized base station course.

3. Ensure that direction is provided by a licensed physician or under the direct supervision of same.

4. Ensure routine auditing of all medical control reports, (i.e., tapes/written) by appropriate personnel.

5. Devise reporting format for prehospital providers to indicate problems with medical control base stations to be submitted to Medical Officer within 24' of incident.

6. Devise reporting format for Base Station physicians to indicate problems with prehospital providers to be submitted to Medical Officer.

Executive Summary

IV. Selection Process

Entry level

- Lack of appropriate medical experience in many of the new hirees.
- Increasing numbers of new hirees who do not have a minimum command of the English language.
- Pool of applicants severely limited.
- No personal screening interviews by medical personnel.
- No pay or benefit parity with firefighters.
- No effective career ladder.
- No effective process to allow entry by reciprocity at ALS levels.

Upgrade

- Inconsistent process for selection for upgrade training.
- 1986 IP selection by DCFD:
  Written score average - 79%
  Practical score average - 64.6 (note change in Selection Process section) no available documentation to substantiate individual performances.
- 1986 IP course pre-test by consortium hospitals:
  40% of class failed to achieve a score of 80% (the course designated passing score) on the written test. Class average - 79%. 100% of the class failed to pass the practical exam in its entirety.

  85% failed medical assessment
  80% failed spinal immobilization
  65% failed airway management
  65% failed fracture immobilization
  50% failed trauma assessment
  30% failed MAST application

- 1986 Paramedic course (4 August 1986)
  88% of IP's for course do not have current EMT certification, some for as long as 3-4 years.
  Status of current CPR certification is questionable.

Recommendations

1. Entry level selection.

   A. Revise process to include personal screening interviews by appropriate medical personnel.

   B. Enlarge applicat pool.

      1. give preference to qualified DC residents but delete residency requirement.*

*Note: DFC Alfred cast a dissenting vote regarding the recommendation for deletion of residency requirement.

Selection Process Recommendations, Cont.

2. make job more attractive.

   a. parity with firefighter pay
   b. increase benefits, i.e.,

      1) health clinic
      2) housing assistance

   c. improve the career ladder (see Organization section)

3. allow appropriately qualified persons to enter at the ALS level.

C. Ensure that a minimum command of English is present.

2. Upgrade Selection

A. Utilize recognized, standardized, validated exam, i.e., National Registry or Regional exam.

B. Utilize interviews, personnel folders, seniority points.

C. Offer preparatory sessions prior to entry for advanced training.

D. Ensure current certification of personnel prior to acceptance into advanced training.

E. Maintain permanent documentation of each individual's progress through selection process.

F. Ensure that the selection process is overseen by appropriate personnel.

Executive Summary

V. Infield Medical Supervision

- Inadequate numbers of shift supervisors to fully evaluate personnel.
- Inadequate training of supervisors in management skills.
- Inadequate ancillary staff in office to generate paperwork.
- No BLS infield evaluations.
- No written criteria for selection of evaluators.
- No written criteria for selection of supervisors.
- No designated pool of evaluators.

Recommendations

1. Develop written criteria for selection of supervisors.

   A. they should be ALS certified.
   B. there should be designated orientation and training programs under appropriate supervision.

2. Increase total number of supervisors to a minimum of 4 per platoon.

   A. 2 office administrative supervisors.
   B. 2 infield/online operational supervisors for evaluation and supervision at all levels.

3. Increase ancillary help in office to adequately handle paperwork.

4. Develop a system by which shift supervisors and evaluators are monitored, directed, and evaluated.

5. Design written criteria for the selection of evaluators from both inside and outside the Department.

6. Create a pool of evaluators within the department so that evaluation of skill performance and maintenance may be done on a daily basis.

7. Develop a specific training program for evaluators.

Executive Summary

VI. Organizational Structure

- Inadequate support for the EAD by the Fire Department and the medical community.
- No parity with firefighting in training, training facilities, salary, or health care benefits.
- No clear cut chain of command.
- Inadequate career ladder.
- No medical accountability to the medical community with regard to quality assurance.

Recommendations

1. Create out-of-department accountability to the medical community in regards to quality assessment. (see Quality Assurance section)

2. Create career ladder by the ranking of the EAD members giving them the same rank and on-line authority as the current ranked fire officers.

3. Increase job satisfaction by creating parity between Firefighting Division and Emergency Ambulance Division in the areas of salary, training benefits and health care benefits.

4. Restructure and reorganize the chain of command so that there are direct channels of communication and lines of authority through the division to the Deputy Chief of the division.

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Executive Summary

VII. Staffing Patterns

- Inadequate numbers of medically trained personnel at all levels.
- Excessive amounts of overtime, i.e., 24 hours at a time.
- Potential for abuse of sick leave policy.

Recommendations

1. Attain adequate staff. (see Selection Process section)

2. Delete practice of consecutive overtime hours to prevent working 24 hours at a time.

3. Consider on-call schedules for ALS personnel rather than "ordering to work".

4. Reexamine Minor Illness Program process and potential for overtime abuse.

Executive Summary

VIII. Equipment

- Inadequate equipment available to deliver the desired quality of care at all levels.
- Inefficient resupply systems at all levels.
- Inadequate documentation of available equipment.
- Inadequate equipment to provide appropriate unit to hospital communications by both BLS and ALS units.

Recommendations

1. Survey should be done throughout the Department to adequately assess the type and amount of equipment necessary to function.

2. All engine companies, truck companies and squads should be provided with the minimum necessary equipment to render care in an emergent situation, i.e.,

   A. Oxygen and the appropriate apparatus to administer it.

   B. Airway equipment in the appropriate sizes.

   C. Bag-valve-mask or positive pressure devices to adequately assure resuscitation of the inadequately ventilating victim.

   D. Blood pressure cuff and stethescope.

   E. Appropriate dressings, bandages and splints.

3. Check list should be provided and filled out daily by the company officers to assure maintenance of equipment on the engines, trucks, and squads.

4. Replacement procedures should be clearly defined to assure access by the engine companies, truck companies, and squads.

5. Basic and advanced ambulances should be adequately stocked with the appropriate equipment.

   A. Special attention need be paid to the acquisition of pediatric equipment such as appropriate masks, airways, splints, C-collars, MAST, angiocaths, defibrillator paddles, etc. to ensure adequate care is being delivered to the pediatric population of the District of Columbia.

   B. Each ambulance should contain adequate numbers of the appropriate types of immobilization devices.

   C. An efficient system for resupplying the ambulance must be developed and implemented to function 24 hours per day.

6. Improve equipment used for unit to hospital communication for both Basic and Medic units.

Executive Summary

IX. System Abuse

- 1 June 1986
  40% of BLS runs resulted in non-transport of patients
  66% of ALS dispatches did not result in patient transport by an ALS unit
- Inadequate public awareness of the proper utilization of an emergency ambulance system.
- Inadequate on-going analysis and follow-up of system abuse and abusers.
- Nonexistent program of alternative transport methods for nonemergent cases.

Recommendations

1. Heighten public awareness through the media, PSA's, booklets and pamphlets. Increase contacts in schools, churches, and community centers. Provide open houses and other high profile measures to make the public aware of available medical services and appropriate usage of that service.

2. Research and review current data and create a new mechanism for assessment of system abuse.

3. Design alternative methods for addressing the abuse within the system which would include one or more of the following:

   A. reevaluate and institute appropriate changes in call prioritizing in a timely fashion.

   B. consider legislation which would allow paramedics the right to refuse transport after seeking appropriate medical control advice.

   C. create legislation to enable prosecution of repeat system abusers.

   D. provide alternate methods of transportation for nonemergency cases by use of vans, buses, or cabs.

Executive Summary

X. Communications

- Processes in excess of 100,000 responses per year.
- Inadequate numbers of dispatcher positions.
- Questionable efficiency of the 911 system by Metropolitan Police Department.
- Lack of standardized dispatcher training.
- Lack of medical supervision of priority dispatch program.
- Questionable evaluation of dispatcher performance.
- Inadequate computerized equipment to process calls and provide data.
- Inadequate revision of priority dispatch system.

Recommendations

1. Reevaluate the 911 system. (MPD)

   A. equipment

   B. increase number of call takers

   C. adequately train the call takers

   D. institute quality assurance measures

2. Update computer equipment to handle volume of calls and provide adequate data collection.

3. Increase number of dispatchers commensurate with number of calls.

4. Require minimum EMT level training Certification, and Recertification as well as standardized Dispatching Course in accordance with DOT standards.

5. Revise the priority dispatch system and retrain personnel.

6. Establish an ongoing evaluation of the dispatchers and the priority dispatch system with written documentation of evaluation in close cooperation with the Medical Officer.

Conclusion

The EMS Task Group (EMSTG) presents their findings and recommendations to the Emergency Medical Services Advisory Committee (EMSAC) with the sincere hope that, if approved, they will be passed on to the Mayor and the appropriate governmental agencies for their expeditious consideration and implementation. Legislative action and D.C. Personnel Department approval may be necessary to effect changes in the areas of "Selection Process" and "Off-Line Medical Control". It is stressed that there are no "quick fixes" to the problems identified and that appropriate solutions will require significant commitment and far reaching changes on the part of the Fire Department. Our ultimate goal is shared with EMSAC and the Fire Department; to provide the best prehospital care for the citizens of and the visitors to our nation's capital. Such care, we feel strongly, can only come out of a system predicated on excellence in patient care and outcome.

The EMSTG realizes that our examination of the system was at best superficial. Despite this, certain problems and issues were clear: training, quality assessment/assurance and medical control. A more comprehensive evaluation by an outside expert might be a reasonable recommendation. We do feel, however, that some of the problems identified are obvious and too urgent to allow significant time to pass without further deterioration in provider morale and patient care. A mechanism for on-going evaluation of the "system" should be instituted by the EMSAC to assure appropriate implementation of approved recommendations and to continue evaluation of prehospital care in the District.

The EMSTG also considered whether EMS should remain within the Fire Department. The "third service" concept was discussed in this light. Our conclusion was that excellence in prehospital care could and has been accomplished in many types of systems (i.e., Fire Department, Third Service, Private, Public Utility) and that it was more dependent on the personnel and structure of the system rather than the type of system. In addition, we feel that where appropriate the private providers in the District should be subject to the same standards as the DCFD.

The EMSTG members wish to express their appreciation to Fire Chief T. R. Coleman for his cooperation and support. Recognition must also be given to Acting Chief McCaffrey and the EAD staff for their cooperation with the Task Group. They also have identified several of the problem areas mentioned in our report and have already embarked on their solution. It is hoped that our report will help them continue in their efforts by engendering the continued support of the Fire Department and the medical community.

Recognition must also be given to the F.D. prehospital care providers. There are many fine firefighters, EMT's, IP's, and P's striving to provide good care. However without direction, training, equipment, and support, their impact on the overall care is minimal and diminishing daily.

A renewal of support and commitment on the part of the Fire Department and the medical community are essential to successful implementation of any of the task group's recommendations. The Fire Department is much more than fire suppression; medical care begins on the streets. Without their active participation in upgrading the system we will continue to witness the decay of prehospital care in the District of Columbia.

Training

Of grave concern is the number of inadequately trained personnel within the Fire Department rendering medical care at present. Not only does this place the patient at risk but it increases the liability of the District Government with each run. Since the fire suppresion division responds to 15,000 medical emergencies per year, placing them first on the scene of accidents and medical incidents, it is highly inappropriate that 98% of them carry no current basic life support (EMT) credentials. An even more profound statistic is that, not only are 100% of the firefighters without current CPR certification but upwards of 42% of all EAD ambulance personnel also lack current CPR certification.

The training school of the EAD is primarily responsible for the initial EMT training as well as the continuing medical education and recertification at the EMT level of all certified members of the ambulance division and fire suppression division within the Fire Department. The problems found by the Task Group in this arena were multiple and complex. Although this should be the cornerstone for the entire service, we found them understaffed in the areas of instructors as well as ancillary help, lacking equipment . and stretched beyond their limited capacities. No approved criteria were found for the selection of instructors, and there is a need for improved medical direction of those instructors present. There was a lack of formalized training and evaluation for the instructors and the record keeping in regards to initial training, recertification and continuing medical education is so inadequate as to allow for upwards of 42% of the EAD personnel to be without current CPR certification. AHA standards require once yearly update, however, EMT recertification is done every two years. The records kept only reflect biannual training and there is no mechanism in place to identify and retrain those individuals whose CPR certification has expired.

Although in charge of continuing medical education for all levels of training, the training academy fails to consistently offer adequate skill performance education at any level. (see attachment A) During didactic sessions particular attention is paid to the ALS providers leaving the BLS persons to filter through the material in an effort to gain their required 12 hours yearly. Another point of contention is that although firefighters are routinely placed out of service to the fire training academy for drills in fire suppression, the same time is not accorded to EAD personnel to maintain their skill levels.

It should be noted that the instructors presently engaged in training at the academy strive to provide the best training possible. However without equipment (there is only one slide projector for the entire school) and teaching aids; without the appropriate ancillary help to keep records and update files; without the appropriate medical support, it is an impossible task to complete. Again note should be made of the fact that no matter how good the initial training is, without continued infield performance evaluation and a mechanism for correcting skill deficiencies, knowledge and skills are rapidly lost.

Training Recommendations

1. Focus the efforts of the EAD Training Academy on upgrading all current personnel to appropriate standards before admitting any new EMT trainees.

2. Hold any new programs such as EMT-D training until such time as all current EAD personnel meet the minimum AHA and DOT standards.

3. Continue upgrade training from EMT to IP or IP to P level as well as endotracheal intubation training at the P level as long as there is a built in mechanism to review basic skills during the upgrade.

4. Ensure that on Priority M incidents that the firefighting units do not cancel incoming medical units unless no patient was found and that proper documentation is made.

5. Develop a plan within 30 days to recertify all Firefighters in CPR and ensure annual recertification.

6. Ensure the support of the medical community for the provision of resources for the initial CPR recertification program.

7. Ensure that all Firefighters currently assigned to Rescue Squads or who will in future be assigned to Rescue Squads be EMT trained, certified, and recertified as required.

8. Train all Firefighters currently assigned to Engine Companies, Truck Companies and the fire boat to 1st responder level.

9. Recertify all EMT's in CPR within 30 days of the final report and ensure annual recertification.

10. Ensure the support of the medical community for the provision of resources for the initial CPR recertification program.

11. Ensure that EMT curriculum is suitable to the level of medical experience of entry level trainees. (see Selection Process)

12. Revise the current EMT recertification program to obtain the following:

    A. put all EMT's on quarterly schedule for recertification as is done with IP's and P's.

    B. require attendance at the recertification classes.

    C. require appropriate CME <u>prior</u> to recertification class, i.e., 12 hours annually.

    D. ensure that individuals whose certification has lapsed are not allowed to return to ambulance duty until certification has been reinstated.

13. Expand the Paramedic Review Board to include the certification, recertification, and decertification of EMT's.

Training Recommendations, Cont.

14. Ensure that EMT continuing medical education:

    A. be appropriate to BLS provider.

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    C. gives credit only for appropriate didactic and skill performance, i.e., not for participating as a victim or evaluator during testing situations.

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    C. recertification in ACLS biannually.

    D. recertification at EMT level for all EMT/IP's biannually.

16. Reorganize ALS CME to include:

    A. practical skills at:

        1) basic level
        2) advanced level

    B. credit be given only for appropriate activities.

    C. pre and post testing for each session.

    D. CME divided 50% per year.

Training Issues

1. Training Academy

    A. Evaluation of course material - revise as appropriate.

    B. Record keeping

        - computerize with local print capability
        - increase ancillary staff to adequately handle paperwork
        - establish adequate filing system

    C. Equipment

        - videotaping capability
        - update A-V equipment
        - update training aides
        - update training library with slides, tapes, books, etc.

Training Recommendations, Cont.

2. Instructors

   A. devise appropriate selection process.

   B. develop written instructor training program.

   C. develop written instructor monitor/evaluation process.

   D. increase instructor staff to at least 10 full time from both ALS and BLS levels.

   E. ensure a fixed schedule to allow adequate "street time" for instructors.

Quality Assurance/Assessment

The Task Group found no evidence of any systematic quality assessment methodology or quality assurance program. Such programs are vital to the efficient and effective operation of any medical institution or agency. A system of quality assessment and a program of quality assurance are necessary to ensure that standards of care are met, that problems within the operation are identified and resolved, and that issues requiring remedial training are identified. Quality assurance is considered of such importance in medicine, that a significant portion of hospital accreditation is devoted to the issue.

The medical record plays an important role in any quality assurance program and is the primary tool used in quality assessment. Within the EAD there was no evidence of any review of the medical record ("run sheet" or 151 form) at the BLS level. At the ALS level run sheet review appeared to be sporadic and without any written criteria upon which to base such review.

Upon request, the Task Group was given the available run sheets for 1 June 1986. The run sheets were then reviewed for 1) completeness of documentation of the computer-read section as well as the narrative and 2) the appropriateness of documented care as measured against nationally accepted standards.

There were 266 run sheets reviewed from BLS units. Of that number only 161 resulted in patient transports. Each section of the forms were reviewed for completeness. The complete summary of the review is attached. (see attachment B) Significant findings on the run sheets documenting patient transports (161 sheets) include:

112 sheets (42%) with no documentation in the section devoted to "prehospital care".

129 sheets (48%) with only one set of vital signs instead of the standard of 2 sets.

80 of the sheets (30%) with one set of vital signs have no time notation.

16 sheets (6%) with no Glascow Coma score on patients who should have had a G.C.S.

10 sheets (3%) with no narrative comments to provide needed information.

107 sheets (40%) with narratives which are inadequate (i.e., "possible miscarriage", but no notation regarding cramping or bleeding).

There were 105 run sheets (40%) which indicated dispatches that did not result in patient transports. Each section of these forms were looked at to determine the reason for non-transport. The complete summary is attached. (see attachment C) Significant findings include:

12 runs (11%) cancelled by various units (i.e., Engine Company, Headquarters).

19 runs (18%) where either no patient was found or the address was nonexistent.

20 runs (19%) which were reassigned to other units.

7 runs (6%) in which the patient was left with an M.P.D. officer.

29 runs (28%) that resulted in refusals of treatment and/or transport.

1 run (.09%) documented as "unconscious, refused transport".

1 run (.09%) documented as D.O.A. There was no documentation that the patient met the criteria for presumption of death.

4 runs (3%) documented as "no EAS needed".

1 run (.09%) documented as "treated on the scene" with no treatment documented.

There is inadequate documentation on all of the runs where the ambulance crew actually saw the patient, i.e., no assessment of the patient's physical or mental state; no documentation to indicate that the crews made any attempt to explain the possible dangers of refusing care.

ALS runs totalled 87 dispatches with 30 (34%) of the runs resulting in patient transports. There were 57 dispatches (66%) which did not generate patient transports. Of note is that 34% of these dispatches were cancelled by Engine Companies and Basic Units. The complete summary is attached. (see attachment) Overall the documentation was somewhat better than on the BLS runs, but the same issues seen previously hold true for both levels.

The lack of appropriate documentation can only result in the inference that the care being rendered is at best poor. The premise in medicine is that what is not documented has not been done.

There is apparently no process by which patient outcome data is analyzed. Indeed, there does not seem to be any process by which such data is or can be generated.

The Task Group also found a great lack of continued supervision as well as infield performance checks at the BLS and ALS levels. Upon leaving the training school and entering the work force, no EMT is re-evaluated on performance skills. There is one OJT period of two to three weeks. Once permanently assigned, the EMT is left to his/her own devices to maintain their skills and knowledge base. At the ALS level, although infield evaluations are required, they are sporadic and inadequately followed through.

The Task Group found no evidence of quality assessment or assurance at the Firefighter level. Of the 1494 firefighters presently in service only 34 have current EMT cards; none have 1st responder and 95-100% do not posess current CPR certification.

Quality Assurance/Assessment Recommendations

1. Develop and ensure a system of quality assurance within the EAD under the guidance of the Commissioner of Public Health in cooperation with the EMSAC.*

   The Medical Officer's performance in the area of quality assurance should be reviewed by an appropriate medical professional(s) selected by the Fire Chief in consultation with the Commissioner of Public Health.**

2. EMT-IP-P

   A. develop an on-going documented infield evaluation process reviewed by appropriate medical personnel.

      field evaluations to occur:

      1) during OJT
      2) twice annually (minimum)

   B. develop criteria to implement a system for consistent and on-going audit of run sheets.

   C. develop a set of criteria for skill performance.

   D. develop a set of criteria for selection and training of evaluators.

   E. develop an organized system by which field evaluators are monitored.

   F. develop an organized remedial training program.

   G. ensure annual CPR recertification.

3. Firefighters

   A. ensure CPR recertification annually.

   B. ensure on-going monitoring of medical activities.

   C. ensure appropriate levels of training.

   D. ensure the availability of appropriate equipment to render aid at all levels.

4. Develop a process for the collection and analysis of patient outcome data in cooperation with the medical community.

* Note: DPC Alfred and S. Brown dissent regarding the inclusion of EMSAC.
** Note: M. Moreau dissents regarding selection of medical professional by Fire Chief.
** Note: S. Adams dissents regarding the lack of involvement by EMSAC.

Medical Control

This particular area is subdivided into two distinct categories. First and foremost is the off-line medical control in the person of the Medical Officer whose position falls within the Fire Department and whose purview should include oversight of the day to day medical operation of the Emergency Ambulance Division. Secondly, there is the on-line medical control provided through the Base Station hospitals. Each of these areas is critically important to the functioning of a well run system.

The position of Medical Officer as perceived by some members of the medical community and rank and file does not meet the needs of the system. The Task Group feels that there should be significant strengthening of medical control within the system. Areas of concern noted were:

1. no documentation of daily audit of run sheets.
2. no clear cut chain of command.
3. weaknesses at the training academy (see Training section).
4. infield evaluations (see Quality Assurance section).
5. timely development, revision, and implementation of protocols, priority dispatching, and run sheets.
6. poor communication with the system's participating hospitals.
7. lack of delineated scope of activity, the means to effect change, and support from the administrative hierarchy of the Fire Department.

We have reviewed comments from a letter written by Dr. Erlich, one of the consultant trauma inspectors, which outline many of the same concerns expressed by the Task Group. Major areas of concern identified by Dr. Erlich were medical command supervision, medical control, quality assessment, quality assurance and selection processes. (see attachment D).

In regards to the on-line medical control, there has been no recent base station course even though both CHNMC and GSECH have just come on-line for pediatric trauma patients. In addition new EMED residents come on-line annually without benefit of a standard base-station course. There appears to be inadequate quality assessment and assurance of both the tapes and the written logs at the Base Station hospitals.

Medical Control Recommendations

Medical Control (off-line)

1. Ensure the presence of a strong, knowledgeable Medical Officer capable of acquiring the support and cooperation of a) the medical community, b) the prehospital provider, and c) the Fire Department administration.

2. Ensure that the qualifications of the Medical Officer include the following:

   A. physician, nurse, or physician assistant.

   B. knowledgeable and experienced in prehospital care.

   C. experienced in education, personnel supervision, and administrative skills.

Medical Control Recommendations, Cont.

Medical Control (off line), Cont.

3. Review, supervision, and evaluation of the Medical Officer's performance.

   A. by appropriate persons within the Fire Department.

   B. by appropriate medical professional/professionals outside the Department.

4. Clarify the chain of command and scope of authority of the Medical Officer regarding:

   A. daily audit of run sheets.

   B. supervision and direction of all training to ensure standards are met.

   C. provision of close supervision of all infield evaluations.

   D. liaison between EAD and all area hospitals and medical community.

   E. responsibility for evaluation of complaints relating to medical issues and reporting to appropriate regulatory agency.

   F. timely development, revision, and implementation of protocols in cooperation with medical community.

   G. day to day supervision over the shift supervisory staff.

5. Provide adequate ancillary personnel to accomplish tasks.

Medical Control (on-line Base Station)

1. Require ACLS certification.

2. Require standardized base station course.

3. Ensure that direction is provided by a licensed physician or under the direct supervision of same.

4. Ensure routine auditing of all medical control reports, (i.e., tapes/written) by appropriate personnel.

5. Devise reporting format for prehospital providers to indicate problems with medical control base stations to be submitted to Medical Officer within 24' of incident.

6. Devise reporting format for Base Station physicians to indicate problems with prehospital providers to be submitted to Medical Officer.

Selection Process

Clearly, this particular area can be subdivided into two distinct parts. The first reflects the selection of entry level personnel into the Department. The second is the selection of individuals from within the Department for upgrade training. Neither process appears to provide manpower of the quality necessary to ensure the desired standard of care.

At present, selection into the Department is apparently entirely dependent upon the action of the D.C. Department of Personnel. Certain criteria which stipulates entry level requirements has been published.t The pool of qualified, experienced personnel has dwindled significantly. Currently individuals are being hired without appropriate medical experience (i.e., psych tech, morgue tech, etc.), without appropriate personal screening interviews and without a minimum command of the English Language. Apparently, the ability to pass the background clearance and the required drug screening is the only valid criteria necessary for hiring. Training of the individuals, however, has not been modified to meet their needs as non-medical students, resulting in decreasing levels of expertise and increasing the chance of failure.

In spite of a crushing manpower shortage at ALS levels, no modification of hiring practice has been made to accommodate the entrance at the ALS level of properly qualified personnel (licensed by reciprocity). Current practice mandates that all personnel, regardless of previous training or experience, enter and retrain at the EMT level.

The process of selection for upgrade training has undergone multiple configurations over the past few years. There is to date no fixed methodology for selection.

The selection process for the 1986 IP class included both a written and a practical examination devised and administered by the F.D. The scores of the written examination taken by 60 EMT's averaged to 79%. In the interim report it was noted, based on documents available at that time, that the total points on the practical exam used for selection for upgrade was 114 points and that the average score was 64.6. Since that time, we have received some documentation that would indicate that the airway testing station was omitted from the practical exam. This being true, the maximum points possible would be 70 thus making 64.6 points a passing grade.

From this group of EMT's 20 were chosen for the IP class. Testing was done the first day of the course to establish a baseline knowledge and skill level. The written exam consisted of 100 EMT level questions similar to the selection exam given prior to the beginning of the course. The practical exam consisted of 6 stations which tested only EMT level skills. The following are the results of the pre-test:

Written:

8 out of 20 (40%) failed to obtain score of 80
7 out of 20 (35%) scored below 85
Range of grades was 61% to 90%

Practical:	Failure %
Medical assessment	85%
Spinal immobilization	80%
Airway management	65%
Fx immobilization (upper/lower extremity)	65%
Trauma assessment	50%
MAST	30%

Of the twenty students tested, no one passed the practical test in its entirety. (see attachment*)

Maintenance of credentials presents problems with upgrade training:

a. In IP class one individual started class without current EMT certification.

b. Out of 16 currently practicing IP's, only 2 are currently in possession of all the required credentials to practice in D.C. (see attachments E,F,G)

Selection Process Recommendations

1. Entry level selection.

   A. Revise process to include personal screening interviews by appropriate medical personnel.

   B. Enlarge applicant pool.

      1. give preference to qualified DC residents but delete residency requirement.*
      2. make job more attractive.

         a. parity with firefighter pay
         b. increase benefits, i.e.,

            1) health clinic
            2) housing assistance

         c. improve the career ladder (see Organization section)

      3. allow appropriately qualified persons to enter at the ALS level.

   C. Ensure that a minimum command of English is present.

*Note: DFC Alfred cast a dissenting vote regarding the recommendation for deletion of residency requirement.

2. Upgrade Selection

   A. Utilize recognized, standardized, validated exam, i.e., National Registry or Regional exam.

   B. Utilize interviews, personnel folders, seniority points.

   C. Offer preparatory sessions prior to entry for advanced training.

   D. Ensure current certification of personnel prior to acceptance into advanced training.

   E. Maintain permanent documentation of each individual's progress through selection process.

   F. Ensure that the selection process is overseen by appropriate personnel.

Infield Medical Supervision

As mentioned in other sections, the best quality assessment and assurance method for the maintenance of performance skills is the infield evaluation by qualified personnel of the individuals providing care within the system. At present, BLS infield evaluation is nonexistent and at the ALS level is sporadic and inadequate. There appears to be no written criteria for the selection of evaluators within the system or even for selection of personnel for promotion to the supervisory level. Also noted were the inadequate numbers of supervisors to oversee the running of the office as well as the day to day field operations.

Infield Medical Supervision Recommendations

1. Develop written criteria for selection of supervisors.

   A. they should be ALS certified.
   B. there should be designated orientation and training programs under appropriate supervision.

2. Increase total number of supervisors to a minimum of 4 per platoon.

   A. 2 office administrative supervisors.
   B. 2 infield/online operational supervisors for evaluation and supervision at all levels.

3. Increase ancillary help in office to adequately handle paperwork.

4. Develop a system by which shift supervisors and evaluators are monitored, directed, and evaluated.

5. Design written criteria for the selection of evaluators from both inside and outside the Department.

6. Create a pool of evaluators within the department so that evaluation of skill performance and maintenance may be done on a daily basis.

7. Develop a specific training program for evaluators.

Organizational Structure

Historically, the Emergency Ambulance Division and in particular Emergency Medical Services has never been top priority within the Fire Department. Additionally, being assigned to the ambulance has always had in the past a negative connotation. It has only been within recent years that the Emergency Ambulance service acquired Division status and attained an identity of its own.

A career as a emergency medical technician, intermediate paramedic, or paramedic within the DCFD presents limited career advancement opportunity. In addition, parity in salary and benefits with the uniformed members of the Fire Department is lacking. Firefighters within the department are privy to full health care at the fire clinic, routine physicals, and screening for communicable diseases while the health care professionals within the same department who are exposed to communicable diseases on a daily basis are expected to provide these services for themselves. Entry level firefighters come into the service at a higher pay scale ($20,644) than members of the EAD ($16,218). It should be noted that EAD members receive night differential, Sunday premium, and work a 40 hour week whereas firefighters work a 48 hour week and do not receive night differential or Sunday premium. Even in terms of skill maintenance, the firefighter has a better chance than the EAD members, since fire companies are routinely placed out of service during working hours to drill at the fire academy while EMT's, IP's, and P's are required to attain 24, 48 or 72 hours of continuing education respectively on their own time. At present, they receive either compensatory time or overtime pay if the CME hours are taken at the Training Academy.

Other dicotomies exist especially in the area of direct chain of command and overall supervision. The rank and file uniformed members of the Fire Department have direct day to day supervision through the company officers at a ratio of 1 officer to approximately 4 men and possess a direct link to the Fire Chief himself through a specific, well-established chain of command from the company officer through the Battalion Chief, the Deputy Chief, and the Assistant Chief. The EAD personnel, however, are sometimes directed through the company officer and sometimes through the EAD shift supervisor. Often, it is unclear as to which avenue should be taken and therefore the most timely solution to the problem is not often found. As to the day to day supervision of the EAD personnel it is often left to overworked, understaffed shift supervisors who must contend with staffing, consumer complaints and time cards as well as to the individual needs of the members of his entire platoon. The ratio of supervisors to personnel on the ambulance per shift routinely is 2 to 40.

Organizational Structure Recommendations

1. Create out-of-department accountability to the medical community in regards to quality assessment. (see Quality Assurance section)

2. Create career ladder by the ranking of the EAD members giving them the same rank and on-line authority as the current ranked fire officers.

3. Increase job satisfaction by creating parity between Firefighting Division and Emergency Ambulance Division in the areas of salary, training benefits and health care benefits.

4. Restructure and reorganize the chain of command so that there are direct channels of communication and lines of authority through the division to the Deputy Chief of the division.

Staffing Patterns

Presently within the EAD of the DCFD there are inadequate numbers of medically trained personnel at all levels to meet the needs of the community at large. Due to the problems described elsewhere with the selection process, an over abundance of overtime is being worked by the current EAD rank and file. In a two week period ALS providers are working an average of 3 overtime shifts (36 hours) and BLS providers 5 overtime shifts (60 hours). Indeed it is possible to be ordered to work 24 hours in a row and required to deliver care to upwards of 40 persons during that time. This can create a situation which has the potential for compromising the care delivered.

It is possible for EAD personnel to call in sick and be given an automatic three days off without requiring physician documentation of illness or injury. This practice promotes unwarranted use of sick leave with a concomitant increase in overtime coverage.

Staffing Patterns Recommendations

1. Attain adequate staff (see Selection Process section).

2. Delete practice of consecutive overtime hours to prevent working 24 hours at a time.

3. Consider on-call schedules for ALS personnel rather than "ordering to work".

4. Reexamine Minor Illness Program process and potential for overtime abuse.

Equipment

It is one thing to provide the community at large with well trained and highly skilled health care providers, however, without the appropriate equipment available to these individuals quality care cannot be rendered. Appropriate equipment, everything from medical control radios to pediatric cervical collars, needs to be made available to all levels of responders so that the consumers receive adequate treatment. Engine companies, truck companies, and squads as well as basic and advanced ambulances must be brought up to minimum equipment standards before the system as a whole can be rendered healthy and the expected level of care can be realized.

Equipment Recommendations

1. Survey should be done throughout the Department to adequately assess the type and amount of equipment necessary to function.

2. All engine companies, truck companies and squads should be provided with the minimum necessary equipment to render care in an emergent situation, i.e.,

   A. Oxygen and the appropriate apparatus to administer it.

   B. Airway equipment in the appropriate sizes.

   C. Bag-valve-mask or positive pressure devices to adequately assure resuscitation of the inadequately ventilating victim.

   D. Blood pressure cuff and stethescope.

   E. Appropriate dressings, bandages and splints.

3. Check list should be provided and filled out daily by the company officers to assure maintenance of equipment on the engines, trucks, and squads.

4. Replacement procedures should be clearly defined to assure access by the engine companies, truck companies, and squads.

5. Basic and advanced ambulances should be adequately stocked with the appropriate equipment.

   A. Special attention need be paid to the acquisition of pediatric equipment such as appropriate masks, airways, splints, C-collars, MAST, angiocaths, defibrillator paddles, etc. to ensure adequate care is being delivered to the pediatric population of the District of Columbia.

   B. Each ambulance should contain adequate numbers of the appropriate types of immobilization devices.

   C. An efficient system for resupplying the ambulance must be developed and implemented to function 24 hours per day.

6. Improve equipment used for unit to hospital communication for both Basic and Medic units.

System Abuse

In a city like Washington, D.C. which generates over 100,000 ambulance responses per year, a certain percentage of those calls will not require emergency care. 35% of these responses do not result in patient transports and of the patients transported an additional 7% are nonemergent. Ambulance responses are generated for all types of incidents including clinic visits and routine doctor's appointments. As there is at present no right to refuse a patient transport it is possible that a significant percentage of the ambulance runs are an abuse of the Emergency Medical Services System. This can present significant problems for an already taxed service when trying to comply with the true emergency needs of the community.

System Abuse Recommendations

1. Heighten public awareness through the media, PSA's, booklets and pamphlets. Increase contacts in schools, churches, and community centers. Provide open houses and other high profile measures to make the public aware of available medical services and appropriate usage of that service.

2. Research and review current data and create a new mechanism for assessment of system abuse.

3. Design alternative methods for addressing the abuse within the system which would include one or more of the following:

   A. reevaluate and institute appropriate changes in call prioritizing in a timely fashion.

   B. consider legislation which would allow paramedics the right to refuse transport after seeking appropriate medical control advice.

   C. create legislation to enable prosecution of repeat system abusers.

   D. provide alternate methods of transportation for nonemergency cases by use of vans, buses, or cabs.

Communications

In any EMS System, the focal point of activity is the communication center. In the District of Columbia this means fielding greater than 100,000 calls per year for the ambulance service alone. Decisions in this vital area are routinely made in regards to which type of response a victim will receive, i.e., medical local, medic unit and/or basic unit, what priority should be set for response, and whether or not the call can be held for a delayed response. All these decisions impact greatly on the care ultimately delivered, yet we found the communications division lacking in not only adequate numbers of trained personnel but also in the necessary updated computerized equipment to adequately do the job. There have even been incidents reported where persons dialing 911 have been asked to hold prior to being helped. Although it should be noted that this in itself is not the responsibility or fault of the Fire Department since the 911 access number is the purview of the Metropolitan Police Department.

Communications Recommendations

1. Reevaluate the 911 system. (MPD)
   - A. equipment
   - B. increase number of call takers
   - C. adequately train the call takers
   - D. institute quality assurance measures
2. Update computer equipment to handle volume of calls and provide adequate data collection.
3. Increase number of dispatchers commensurate with number of calls.
4. Require minimum EMT level training Certification, and Recertification as well as standardized Dispatching Course in accordance with DOT standards.
5. Revise the priority dispatch system and retrain personnel.
6. Establish an on-going evaluation of the dispatchers and the priority dispatch system with written documentation of evaluation in close cooperation with the Medical Officer.

ATTACHMENTS

D Form 191

GOVERNMENT OF THE DISTRICT OF COLUMBIA
FIRE DEPARTMENT
WASHINGTON, D. C. 20001

December 10, 1985

CONTINUING MEDICAL EDUCATION GUIDELINES
FOR PARTICIPATING HOSPITALS

Hospitals participating in the District of Columbia Fire Department Continuing Medical Education (CME) Program are requested to provide appropriate physician/nurse support for specific subject matters pertaining to prehospital emergency care.

CME classes are scheduled every Wednesday during the months of January thru November, 1986 from 0900 - 1200 hours or 0900 - 1300 hours depending on subject matter. It is preferred each hospital participating in CME, conduct classes each Wednesday for a month, if possible. This would enable each participating hospital to rotate on a monthly basis.

Hospitals are additionally requested to provide a back-up lecturer in event of sudden or unexpected cancellation of the original lecturer.

I feel the hospitals are an essential and integral source of providing expertise and guidance to Continuing Medical Education Program for BLS and ALS providers in the District of Columbia. I wholeheartedly solicit your support, cooperation, and input in making CME for 1986 more meaningful and successful.

Thank you,

Danny R. Mott

Danny R. Mott
Acting Assistant Director,
Training

ATTACHMENT A

CME - PROPOSED TOPICS FOR 1986

1. Pediatric Emergencies (Child Abuse)
2. Hypothermia/Frostbite
3. Water and Ice Related Accidents/Near Drowning
4. Geriatric Emergencies/Hypo and Hyperthermia
5. IV Theraphy, Drip Rates and Doseages
6. Show and Tell (New Equipment)
7. Review of Protocols
8. Case HX: Review - Medical Emergencies
9. Disaster Management & Multiple Patients (Mass Casualty)
10. Haz. Mat. (Approach to Incident Management)
11. Stress Management
12. Alcohol and Drug Abuse
13. Altered Mental Status/Injuries
14. Communicable Disease
15. Resp. Distress (Asthma, CHF, Pulmonary Embolism)
16. Sickle Cell Crisis
17. Anaphylaxis (Animal and Insect Bites, Rabies)
18. Musculoskeletal Injuries
19. Extrication and Spinal Immobilization/Workshop
20. Cardiac Emergency (Chest Pains) Dysrkythmia & Pharmocology acute
21. Trauma Management
22. Burn Management/Electrical Injuries
23. Diabetes Mellitus
24. Renal Dialysis
25. Emergency Health/Sign Language
26. Head and Facial Injuries
27. Penetrating Wounds to the Chest (Including Blunt Injuries)
28. The Distrubed and Unruly Patient
29. High Risk Obstetrical Patient
30. Cardiovascular Problems and Stroke
31. Central Nervous System
32. EMS and the Law

OVERDOSE + TOXICOLOGY

CONTINUING MEDICAL EDUCATION SCHEDULE FOR 1986

*CME classes will be conducted every Wednesday during the months of January through November, 1986; except when a Wednesday conflicts with a holiday. CME sessions will be conducted 0900-1200 hours or 0900-1300 hours, depending on subject matter.

January 22, 1986	May 14, 1986	August 27, 1986
January 29, 1986	May 21, 1986	September 3, 1986
February 5, 1986	May 28, 1986	September 10, 1986
February 12, 1986	June 4, 1986	September 17, 1986
February 19, 1986	June 11, 1986	September 24, 1986
February 26, 1986	June 18, 1986	October 1, 1986
March 5, 1986	June 25, 1986	October 8, 1986
March 12, 1986	July 2, 1986	October 15, 1986
March 19, 1986	July 9, 1986	October 22, 1986
March 26, 1986	July 16, 1986	October 29, 1986
April 2, 1986	July 23, 1986	November 5, 1986
April 9, 1986	July 30, 1986	November 12, 1986
April 16, 1986	August 6, 1986	November 19, 1986
April 23, 1986	August 13, 1986	November 26, 1986
April 30, 1986	August 20, 1986	
May 7, 1986		

Transports

BLS Summary

Transports - 161
Documentation

Scene Priority		
none	12	(2)
wrong	5	(2)
Chief Complaint		
none	9	(2)
wrong	13	
Prehospital Care		
none	112	(11)
Sex/Age/Race		
none	34	(4)
wrong	1 (male with LMP)	
Choice of Hospital Reason		
none	25	(4)
Mode of transport		
none	10	(6)
Ambulance Assist		
none	18	(3)
"other"	10	(0)
Injury		
none	19	(1)
Vital Signs #1		
none	5	(1)
by palp	8	(0)
Vital Signs #2		
none	129	(18)
by palp	3	(0)

ALS Summary (bold)

Transports - 30

Time		
none	30	(20)
Time		
none	133	(21)

ATTACHMENT B1

Transports Cont.

BLS Summary			ALS Summary (bold)		
Resp Effort					
none	5	(1)			
Lung sounds					
none	6	(1)			
Motor Response					
none	3	(0)			
Verbal Response					
none	4	(0)			
Eye opening					
none	3	(0)			
GCS #1			GSC #2		
none	16	(1)	none	40	(7)
wrong	1		wrong	3	
Trauma Score #1			Trauma Score #2		
none	15	(2)	none	18	(2)
wrong	3		wrong	3	
Temp					
none	3	(1)	EKG_1 (3)	T_1 (6)	
Pupils			EKG_2 (1)	T_2 (4)	
none	2	(0)	MEDS (0)	Time (1)	
Scene Response			Proto/Radio		(1)
Narrative					
none	10	(0)			
inadequate	104	(19)			

ATTACHMENT B2

Non Transports

BLS Summary - 105
ALS Summary - 57

Reassigned

BLS to ALS - 13
ALS to BLS - 9

BLS to BLS - 7

Treated on Scene & Left

BLS - 1
ALS - 0

Refusal of Treatment/Transport

BLS - 11 (without signed release) \ 29
18 (with signed release) /
ALS - 5

Cancelled

by	BLS	ALS
Medic	3	-0-
Eng Co	-0-	9
BLS	-0-	10
?	1	5
HQ	8	3
No pt/address	19	6

Other

	BLS	ALS
no "eas" needed	4	1
Pt tx by PVT. Car	4	1
Blank 151	1	2
Left with MPD	7	0
Trans by MPD	1	
Detail/Fireground	4	

Narrative/Patient Assessment

BLS	ALS
none	one

ATTACHMENT C

The National Registry
of
Emergency
Medical
Technicians®

Board Certification

Registered EMT-Intermediate

ATTACHMENT E

EMT-INTERMEDIATE CONTINUING EDUCATION REQUIREMENTS FOR REREGISTRATION

Reregistration is awarded on a biennial basis (once every two years) upon completion and verification of the required continuing education and submission of the $10.00 reregistration fee.

Qualifications for Reregistration

To renew registration, applicant must:

1. Be actively working within the emergency ambulance service, rescue service, or patient/health care setting, performing the required EMT-Intermediate skills.
2. Complete all continuing education requirements prior to expiration date.
3. Complete reregistration and continuing education report, and return this information with the reregistration fee to the National Registry office, and
4. Submit proper verification as stated or required.

Note: Reregistration report forms and instructions are mailed the first of November, prior to the December 31 expiration date. Reregistration forms must be submitted no later than March 31 of the following year. There are no time extensions granted for reregistration.

Continuing education requirements include:

1. Mandatory completion of a state approved EMT-A Refresher Course with written and practical examinations;
2. Mandatory annual CPR certification.
3. Completion of 12 hours of refresher training adhering to the content of Modules 1.2.3. and EOA of the National EMT-P Curriculum;
4. Accumulation of an additional 36 hours of continuing education as outlined within the following pages;
5. Statement of skill maintenance by Physician Director or EMT-Intermediate training/operations.

LAPSED REGISTRATION

To be reinstated once EMT-Intermediate National Registration has lapsed, candidates must:

If lapsed within a two-year period, successfully complete a state-approved National Standard Basic EMT Refresher Training Course and state-approved 12 hours of refresher training, adhering to the current National Standard EMT-Intermediate Curriculum; submit a new application and fee; and successfully complete the written and practical examinations.

If lapsed beyond a two-year period and still currently state-certified at the EMT-Intermediate level, successfully complete a state-approved National Standard Basic EMT Refresher Training Course and state-approved 12 hours of refresher training, adhering to the current National Standard EMT-Intermediate Curriculum; submit a new application and fee; and successfully complete the written and practical examinations.

If lapsed beyond a two-year period and state certification at the EMT-Intermediate level has also lapsed, successfully complete a state-approved current National Standard EMT-Intermediate Training Course, as well as a state-approved National Standard Basic EMT Training Course; submit a new application and fee; and successfully complete the written and practical examinations.

PLEASE NOTE: If the lapsed EMT-Intermediate registrant has maintained current state/national Basic EMT certification, the lapsed registrant is required only to show evidence of successful completion of a state-approved National Standard Basic EMT Refresher Course, completed within the past two years, and successful completion of a state-approved National Standard EMT-Intermediate Training Course.

State certified EMT-Intermediate candidates seeking initial entry must show evidence of successful completion of a state-approved current National Standard Basic EMT Refresher Course and successful completion of state-approved 12 hours of refresher training, adhering to the current National Standard EMT-Intermediate Curriculum completed within the past two years, prior to submission of application and fee.

81-801 O - 88 - 3

DCMR 29

PUBLIC WELFARE

★ ★ ★

D.C. OFFICE OF DOCUMENTS

SEPTEMBER 1985

MARION BARRY, JR.
MAYOR

ATTACHMENT 7

AVIS T. HAWKINS
DIRECTOR OF DOCUMENTS

504 EMERGENCY MEDICAL TECHNICIANS AND TECHNICIAN/PARAMEDICS (Continued)

504.11 The Mayor, on or before October 28, 1977, shall with the assistance of the District Advisory Committee for Emergency Medical Services promulgate rules and regulations establishing standards and procedures for the certification of emergency medical technician/intermediate paramedics.

504.12 The standards and procedures issued under §504.11 shall include the following:

(a) A requirement for the satisfactory completion of a training course in emergency care approved by the EMS Advisory Committee, consisting of not less than one hundred (100) hours of classroom and practical instruction, including, but not limited, to, instruction in the following:

(1) All phases of basic life support; and

(2) The administration of drugs and intravenous solutions under the written or oral communication, either directly or via telecommunication, of a licensed physician;

(b) A requirement for the initial and the continual determination of skills through oral, written, and practical examinations;

(c) Provisions prescribing the life support services that may be provided by emergency medical technician/intermediate paramedics, including those services which require the supervision by telecommunication of a licensed physician;

(d) Provisions for the continuity of emergency medical care and assistance across state borders, including a provision for the reciprocal recognition of medical personnel certified or licensed by other jurisdictions; Provided, that this section shall not be construed to allow these personnel to perform any services which they are not licensed or certified by the parent jurisdiction to perform; and

(e) Provisions for the renewal, denial, suspension, and revocation of certification; Provided, that an examination for the renewal of the certification of an emergency medical technician/intermediate paramedic shall be required at least every twenty-four (24) months.

504.13 No applicant may be certified as an emergency medical technician/intermediate paramedic unless the applicant has satisfied all conditions for certification as an emergency medical technician as required under this section.

504.14 During the practical portion of the training program specified in §504.12, the emergency medical technician/intermediate paramedic trainee shall be supervised continuously by a physician or by a registered nurse.

(a) Shall have successfully completed at least two-hundred (200) hours of classroom and clinical training at an appropriate training program approved by the CPH/OEHMS, and in accordance with the guidelines of the U S Department of Transportation,

(b) Shall have passed the appropriate National Registry Examination; and

(c) Shall have Advanced Cardiac Life Support (ACLS) certification

Applicants shall also be approved by the Director or his/her designee in accordance with these regulations before a certificate is issued

504.30 To maintain a valid EMT/IP certificate, the holder of the certificate shall have successfully completed the National Registry recertification requirements for recertification at the EMT/IP level, Advanced Cardiac Life Support (ACLS) certification, and shall provide evidence of two-hundred (200) hours of riding on a medic unit per year

ATTACHMENT G

Mr. PARRIS. Both of these studies express significant concern about the medical—excuse me—the lack of medical control over the system. As Dr. Ehrlich has pointed out, the D.C. EMS system is "lacking perhaps the most important feature of a good EMS system, and that is proper medical control for the system. Without medical control, no EMS system can achieve the necessary level of function to adequately serve its community."

Now I asked the ambulance driver, a young lady that I went with on my ventures into the EMS system here in the city, what is it that you think would be most helpful? If I had the ability to deliver to you one thing that would make your job easier and better, more efficient for the benefit of the people that you try to serve, what would it be? Her answer was, direct medical control, that there is simply not enough professionalism, if that's the right word, that is injected into the level of the trainees who, obviously, are not and cannot be—unreasonable to expect that they would be—trained medical personnel.

I do not believe, Mr. Chairman, that emergency medical service should be on-the-job training. It is simply too important for that. Consequently, training and the control, the supervisory input from professional people, I think, needs to be increased and improved.

Other witnesses who will appear before this subcommittee, I think I'm reliably informed, will make the same point. So I will move on.

Mr. Fishburne makes a valid point in his testimony that, if you wouldn't have police officials controlling the fire department or EMS personnel controlling the police department, then why would you have the fire department controlling the emergency medical system? It simply doesn't make any sense to me. They are three different functions requiring totally different and unique training and expertise.

Another point made by nearly all of those present today is the negative impact that the residency requirement has had on the ability of the service to attract and retain the most qualified individuals possible. Dr. Ehrlich in his report stated: "The regulation, with all of its good intent, will only hinder the development of the city's EMS program. I would, therefore . . ."—These are his words, Dr. Ehrlich's.—". . . suggest that your current residency rule restricts your list of applicants to the point where you are depriving yourselves of the most qualified individuals." This, from a recognized expert.

Of course, as my friend and chairman of this subcommittee from the District of Columbia well knows, that is not a new revelation. It's not a new issue. We've plowed that ground many times before, but we have seen the adverse, serious impact of the residency requirement on the D.C.'s police and fire departments' ability to attract and retain qualified personnel. As a matter of fact, it's been proven, I hope, to the satisfaction of all of us.

The problem is, of course, that the city refuses to acknowledge what I believe is the faulty logic, and instead only lowers the hiring requirements, and thereby depreciates and adversely impacts again the quality and the training of the people. Not that they're not good, sincere, hardworking, dedicated people; they

simply are not qualified. As we reduce the qualifications, we reduce the quality of the service.

So I ask when is this city going to wake up and smell the coffee? They ought to simply acknowledge the fact that in many respects the policy is wrong, simply not working in the real world for the benefit of the residents and the visitors of this great city, our Nation's Capital.

Fourteen hundred ninety-four firefighters in the city do not have current CPR certification; 100 percent of firefighters, often the first to arrive on the scene of an accident, do not have first responder training; 42 percent of EAD personnel, if you can believe it, do not have current CPR certification. Firefighters assigned to rescue squads do not, for the most part, have emergency medical technician training.

I've got to tell you that all of those figures simply scare me to death, not for just those of us at this table here in this room, but for the people who make this city their home. We can do better, and we should do better. We must do better.

We're here, all of us, to help bring that about.

The report of the Mayor's EMS task force is very comprehensive. It goes into the issues of training, quality assessment and assurance, medical control, in field medical supervision, organizational structure of the system, staffing, equipment, communications, abuse of the service by the community, all of those things. I look forward to hearing from Dr. Chen who is the chairman of that task force, as well as from two other professionals who put that report together, members of the task force. Dr. Champion, chief of trauma at the Washington Hospital Center, world renowned expert on the subject of critical care, contributed a great deal to that report. It deserves much more attention than it's received.

The professional emergency care experts know that the District's EMS system is sorely in need of improvement and perhaps major overhaul, but when the average guy on the street can tell you with surprising accuracy what the problems are and where the problems are, you know you've got a problem.

The city has to recognize that fact. It has to recognize that public confidence in the emergency care system of a city, such as this one, is almost as important as the viability of the system itself. You can't have one without the other. If there is no confidence, then there is no viability.

It's time for the city to say—to stop saying, leave us alone; this is a home rule issue; it's all under control; this is just media hype; none of these things apply. That's simply not true. This is a public safety issue, pure and simple; and it's been one, it is one that's been allowed to go on for too long, in my view.

It is time for the city to stand up, acknowledge what errors exist, shortcomings, if any. Just do something about it now, not later. We need real action now; not the kind of action that was attempted to be shown last month. When we put out statistics showing that the average ambulance response time had been shortened by about 3 minutes, in fact all the city really did is start calculating the response time differently. They started counting from the time the vehicle is dispatched instead of the time the call is received, and they call that a 3-minute improvement in response time.

The question should legitimately be asked, it seems to me: How come when you get a call, it takes you 3 minutes to get in the vehicle to leave the fire station? That's the question, not have we shortened the period by 3 minutes. Why does it take 3 more minutes to get going?

It seems to me that it's time not to have another study that perhaps will be again ignored. The jury is in. Sentence should be community service. That's what we all desire including, I might add, people in the city administration responsible for this. They would like to do better. Let's help them. I hope, Mr. Chairman, these hearings will be a step in that direction. I thank you.

[The prepared statement of Mr. Parris follows:]

THE HONORABLE STAN PARRIS
STATEMENT
EMERGENCY MEDICAL SERVICE IN THE DISTRICT OF COLUMBIA
D.C. SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH
AUGUST 5, 1987

Thank you, Mr. Chairman. I might say how very pleased I am that we were finally able to schedule these very important hearings.

Mr. Chairman, I have requested that a number of professionals and experts from all facets of the city's emergency care system appear before this subcommittee today so that we might get a ~~pretty~~ clear reading of where the system has been, where we are today, and where we may be going in the future. It is my hope that this important exercise will be more than a little helpful in providing some guidance to the city towards making some constructive and substantive changes in the current EMS system.

The inadequacies of the current operation are, in my judgment, self evident. These problems have received a great deal of attention in the local, national and international media. Some might ask, "Why all this attention? Why is the national and international media so interested in what is going on in this little city?" The answers to these questions, too, are self evident.

Washington D.C. is not your typical metropolitan area -- this is the seat of our national government. In addition, Washington

plays host to literally hundreds of thousands of American and foreign tourists every year, and is the site of the principal embassies of nearly every nation in the world. In short, the residents of this city are not the only ones with a vested interest in having an efficient and effective Emergency Medical Service in the District of Columbia. That is why we are having these hearings.

I am not going into this hearing ignorant of the facts or of the current system -- a great deal of my time has been dedicated to this matter. I recently spent several hours riding with Medic Unit #9 in Southeast Washington, and a member of my staff has spent almost twenty hours riding with Ambulance and Medic units in virtually every area of the city.

While I believe strongly that these hearings will be successful in coming up with some very constructive ideas on how to improve the EMS, I am even more concerned that they will fall on deaf ears of the city. There is good cause for my concerns. I have had an opportunity to study the report of Dr. Frank E. Ehrlich, an EMS expert who has inspected over 50 trauma centers and EMS systems. Dr. Ehrlich was asked to review the District's system by the City's Commissioner of Public Health, Dr. Andrew McBride. I have a copy of Dr. Ehrlich's report here, dated May 30, 1986, and am told that no action has been taken on any of the recommendations.

I also have in front of me a copy of the July 1986 report and recommendations of Mayor Barry's EMS Advisory Committee. That report is highly critical of the current EMS system and the way in which it is being managed by the city.

My point in all of this is that those two reports were comprehensive and constructive -- the studies were conducted by highly respected experts in the field -- and both of these critical reports have been all but ignored by the city. Once again, this is my greatest concern about these hearings -- that the resultant recommendations will be ignored. I want to point out that we are not here to dictate what should be done, but I am here to say that something must be done!

At this point, I would ask that both of these reports be inserted into the record in their entirety and I would take just a moment here to talk about some of the findings -- we'll get into the substance during the question and answer phase.

Both of the studies expressed significant concern about the lack of medical control over the system. As Dr. Ehrlich pointed out, the D.C. EMS system is "lacking perhaps the most important feature of a good EMS system and that is proper medical control for the system...Without medical control, no EMS system can achieve the necessary level of function to adequately serve its community." Other witnesses who will appear before this committee today will speak to this same subject. Mr. Fishburne makes a

valid point in his testimony that if you wouldn't have police officials controlling the fire department, or EMS personnel controlling the police department, then why would you have the fire department controlling the emergency medical system? They are three different functions requiring totally unique training and expertise.

Another point made by nearly all of those present today is the negative impact the District's residency requirement has had on the ability of the service to attract and retain the most qualified individuals possible. As Dr. Ehrlich stated in his report, "the regulation with all of its good intent will only hinder the development of your EMS program...I would therefore, suggest that your current residency rule restricts your list of applicants to the point where you are depriving yourselves of the most qualified individuals." Of course, as my friend from the District of Columbia well knows, that is not a new revelation. We have seen the serious adverse impact of the residency requirement on the District's police and fire departments ability to attract and retain qualified personnel -- as a matter of fact, we have proven it. The problem here is, of course, that the city refuses to acknowledge the faulty logic and instead only lowers the hiring requirements. Just when, I might ask, is the city going to wake up and smell the coffee? They ought to simply acknowledge the fact that in many respects the policy is wrong and is not working to the benefit of the residents of and visitors to this great city -- our nation's capitol.

It is very disturbing to note in the EMS Task Force report that 100% of all 1494 firefighters in this city do not have current CPR certification; 100% of firefighters, often the first on the scene of an accident or fire, do not have 1st responder training; 42% of EAD personnel, if you can believe it, do not have current CPR certification; and firefighters assigned to rescue squads do not, for the most part, have Emergency Medical Technician (EMT) training. Now, I've got to tell you, all of this scares me to death.

The Report of the Mayor's EMS Task Force is very comprehensive. It goes into issues of training, quality assessment and assurance, medical control and infield medical supervision, the organizational structure of the system, staffing, equipment, communications, and the abuse of the service by the community. I look forward to hearing the testimony of Dr. Chen, the chairman of that task force, as well as from two other professionals who put this report together as members of the task force. I also look forward to hearing from Dr. Howard Champion, Chief of Trauma at the Washington Hospital Center and a world reknowned expert on the subject of critical care.

The professional emergency care experts know that the District's EMS system is sorely in need of a major overhaul; but, when the average guy on the street can tell you with surprising accuracy what the problems are and where the problems are, you know you've got a problem. The city has got to recognize this.

The city has also got to recognize that public confidence in the emergency care system of a city such as Washington is almost as important as the viability of the system itself -- you can't have one without the other.

It is time for the city to stop saying "leave us alone, this is a Home Rule issue" and "its all under control" and "this is all just media hype with racial overtones." Fact is, none of those things apply. This a public safety issue, pure and simple, and its been allowed to go on for far too long. It is time for the city to stand up, acknowledge their errors and just do something about it -- now, not later. We need real action now -- not the kind of action the Mayor tried to sell the public last month when he released statistics showing that the average ambulance response time had been shortened by about three minutes when, in fact, the city simply started calculating the response time differently -- from the time a vehicle is dispatched instead of the time the call is recieved. Let's not have another study that will be ignored -- the jury is in, and the sentence should be "community service" -- let's fix the system.

Mr. FAUNTROY. I thank the gentleman. The gentleman was not here when in my opening statement I commended him for the enormous amount of time and energy he's devoted to a problem which all of us keenly feel in the Nation's Capital and, indeed, across the Nation. We appreciate your interest, and we look forward now to the hearing and our first witness.

Mr. PARRIS. If the gentleman would yield just a moment.

Mr. FAUNTROY. Be happy to.

Mr. PARRIS. Let me once again, Mr. Chairman, apologize, as I did earlier, for being tardy in arriving. I do—I now have glanced at a copy of your statement. I'm very grateful for your kind words. Thank you.

Mr. FAUNTROY. Thank you.

Our first witness is Mr. Thomas M. Downs who is our city administrator and deputy mayor for operations of the District of Columbia government. Mr. Downs, it's a real pleasure to have you to open the hearing and, if you will identify those who accompany you, you may proceed in whatever manner you choose to present your statement to the committee.

STATEMENT OF THOMAS M. DOWNS, CITY ADMINISTRATOR AND DEPUTY MAYOR FOR OPERATIONS, DISTRICT OF COLUMBIA GOVERNMENT

Mr. DOWNS. Thank you, Mr. Chairman. It's my pleasure to appear before you this morning. I have on my left Dr. Beverly Coleman-Miller from the commission on public health who is the medical officer responsible for oversight of the quality assurance, quality of care issues in the emergency ambulance bureau.

On my right is Mr. Joe Yeldell who is the head of the Mayor's office of emergency preparedness who has been coordinating issues around response time, E–911, fire department and commission on public health; and Chief Coleman, the chief of the fire department is responsible for their emergency ambulance bureau.

I have a lengthier statement, but in the interest of time I would ask that it be entered into the record and that I will give you a couple of brief remarks from it and then allow the time for questioning. I know the committee is interested in that.

Mr. FAUNTROY. Without objection, so ordered.

Mr. DOWNS. First, let me say that there is a loose term of art called the 911 problem. It has been exacerbated in part by the way the media loosely construes the problem that they perceive with the ambulance service as a 911 problem. The Post is not much help in terms of several of the editorials which call it the 911 problem.

E–911 is a service response mechanism for the police department, the fire department and the ambulance service. I have not heard criticisms about responsiveness or professionalism about the D.C. Metropolitan Police Department or the fire department. We have had criticisms about the ambulance service, and it's an important distinction; because in some cases we're finding people who, because they perceive there to be a problem with E–911, have been trying to get the operator to make their calls for them. That shortens the response time, and it deprives the police department which runs the E–911 system of some valuable information that is provid-

ed by the E–911 system, that is, the number and the location of the caller in case that information is necessary.

We also know that we have one of the highest demand call ratios in the country of any city, due in part because we have so many international and domestic visitors to Washington, as Mr. Parris pointed out. We are a visitor's capital of the world as well. In order to try and solve some of those problems we set up a separate nonemergency, noncritical phone system call 8DC–HELP. Anything that is of a nonemergency nature from a backup in a sewer to a cat in a tree is channeled to that, to take the load off of the E–911 system.

It is the first in the Nation and a model for other cities. We've had a lot of interest from other cities in the United States about copying this system to divert calls off the 911 system, and it's starting to have an impact, relieving the burden off the emergency response system.

I would point out, as you did earlier, that E–911 systems are not without their troubles, as our neighboring jurisdiction across the river, Fairfax County, has discovered as well. They had to put out a notice over the air that you should not call 911 for a while, because it was not working.

Our system does work. 911's response on the police side where they pick up the incoming is between 4 and 5 seconds average, and no more than 5, demonstrated day after day, hour after hour, shift after shift.

The issue more pertinently before the committee is that of the nature and quality of care of the emergency ambulance service. I'll skip over a lot of the history of it and get to several issues that have arisen in the media and in the public's mind about the ambulance service.

There was a lot of concern about the fact that we had, at one point, as one station began to describe it, the worst ambulance system in the United States, based on response time and at some point questions about the quality of care being rendered. We did a 30 survey—my office on management and productivity did a survey of the 30 largest cities in the United States and their ambulance service, talking directly with the managers of those services, to find out what was happening within their systems.

We found that it is not at all a unique Washington, DC problem. Almost every city said that they were having an explosion in call demand, a increasing demand on the service around the clock and around the year. We found that we were the second highest call demand system in the United States, second only to St. Louis, and we were second by a very small margin, probably due in great part to the number of visitors that we have here who use the 911 system.

It showed that, as far as response time, out of 29 cities we were 9th in the United States in overall response time, and that in some cases cities were trying to get to an area of response time that we were already at and considered unacceptable. For instance, Phoenix is trying to get to 10 minutes response time anywhere within Phoenix. New York City is pushing 14 minutes as its average response time. Other major metropolitan areas around the country are having this same problem about response time.

I'm not using that in any way, shape, fashion or form as a parameter acceptable for the Nation's Capital, that it sets a mark; but it simply provides a context that what is happening in ambulance service is not unusual in any major jurisdiction in the United States as far as we can tell.

The particular issues that are raised by the EMS advisory committee, the review of the priority dispatch system, the earlier review of the quality of care, in many cases, conflict with each other. As I was reading through them, I could find divergent opinions depending on your perspective. If you are talking to a paramedic, there is one problem. If you are talking to a physician, there is another problem. If you're talking to a firefighter, there is another. If you're talking to an ER, an emergency room physician, you've got another problem.

There is a lot of interest in improving the system. We have found that the real challenge is to find a common ground for the best system in the country. In that light, we have accepted the recommendations where they are nonconflicting with each other within those reports, and have set out after consultation with the Communication Workers of America and AFGE, who are the ambulance personnel, with their input into a number of issues, worked out a master list of about 135 specific improvement steps within the service that need to be taken.

The issue and resolution agenda is moving along, and I'll try and hit the highlights of that. But several other steps have been taken as well within the government that I think bear on your concerns.

The ambulance service was elevated to bureau status. That is a level immediately below the chief, rather than a division which operates within a bureau. So that there is a direct accountability to the cabinet member responsible for the service. I'll get to Mr. Parris' point a little later about why, within a fire service.

We have committed to and are now actively recruiting the finest civilian ambulance director that we can find from around the country. We scheduled the last round of interviews, and I expect shortly to have a announcement from the Mayor and the chief and myself about a director of that ambulance service. We've had a very good response from this national recruitment. As a matter of fact, we've had more people than we anticipated; and that's what has set the process back a little bit.

Medical oversight and monitoring, which was pointed out, is critical. Notwithstanding the media, there is a cooperative arrangement between Dr. Tuckson's office to Dr. Coleman-Miller with the fire department to Chief Coleman and Mr. Yeldell, to follow up on every unusual incident report that is filed by any person within either the fire department or within the ambulance service. There is a review of the tapes involved in that, and issues of quality of care medical procedure and ongoing training are addressed by the commission of public health.

That daily meeting review process takes place every day. I'm sure it's getting to the point where Dr. Coleman-Miller would probably prefer not to see another unusual incident report, but it is proceeding. It's in place, and it will continue to be in place.

All firefighters are being trained to the EMT level, and within a few weeks all 33 engine companies will have at least one EMT as-

signed to it, which is a reason for close coordination between the ambulance service and the fire service. EMTs on the scene are qualified to stabilize patients.

There are two things about an ambulance service that are essential. The first is to stabilize the patient. The second is to transport. The ability of a number of systems around the country, Baltimore, Miami, Atlanta, to have trained firefighter personnel at the EMT level on the company, be able to respond as first responder, is essential to their systems. There is a reason for that.

There are more fire stations, more fire companies and less demand on fire time than there are on ambulance time. So in about 75 percent of the cases, you can get a fire company to the scene before you can a medic unit; and that's not unusual for any service in this region or any service around the country.

It means being able to put EMT trained firefighters on the scene within 2 to 3 minutes in almost every instance. The backup to that, if there is not an EMT equipped fire company available, one of the city's four rescue squads will be immediately dispatched. They all have EMT trained firefighters on board.

We've had a radio communications problem, widely recognized. We only have one channel for ambulance service. By mid-September we will have a significant improvement in that by having two channels available, one for tactical and one for administrative within the ambulance service and freeing up the air time that is necessary for the ambulance service to be supported.

We've filled all of our dispatcher positions and have an additional nine dispatchers in the process of being hired now to provide two additional work stations on the floor.

A mental health counselor was hired to provide stress counseling and support to ambulance dispatcher and firefighter personnel on local medic runs. We currently have 21 BLS and ALS units in service and five fully equipped units in reserve for ready replacement, if needed. The maintenance operation to support those is now 24 hours a day rather than regular workaday workweek.

We've established an open recruitment without limit to assure a proper pool of qualified personnel at the EMT, the intermediate paramedic and the paramedic positions at all times, and have begun the process of recruitment not just at the EMT level but, like most other jurisdictions, now recruiting for individuals who have current intermediate paramedic or current paramedic cards.

We have, as I mentioned, the medical review process in place. We have a thorough, ongoing evaluation of our priority dispatch system underway, not only from Dr. Clausen who was kind enough to give us a report from his perspective of the dispatch system, but also locally by medical providers from the hospital based provider community.

We are in the process of replacing the entire fire department radio system with a state of the art 800 Mhz trunking system which will give us the flexibility to provide almost limitless channels for the department replacement of the existing CAD, the computer assisted dispatch system which is one of our oldest pieces of computer technology left in the District from the seventies, and that will greatly enhance the allocation of resources.

We're developing an apprenticeship program in the D.C. public schools in the area of emergency medical services for both EMTs and dispatchers, to have a steady stream of qualified individuals coming out of the D.C. public schools in these areas. We have the provision of infield evaluators for the evaluation of all EMT's, IP's and P's who provide medical services—a quality control monitoring step.

We're developing a process that will, hopefully, address some of these nonemergency transport needs. We're at the point of making some decisions about a vehicle status and vehicle locator system, and will have a high level committee review ongoing monitoring and evaluation of the emergency ambulance service.

We are committed to developing the finest ambulance service in the country. We have no reservation about admitting that we have had problems in the past several years over the ambulance service, the explosive growth and demand on calls, the problems with the communications that back up that, appropriate backup training and support for the ambulance crews and communications workers themselves.

We can state, though, that we are shooting for a system without error, that error is unacceptable. We know that in any system that is mechanical and human, there will be failures. We are striving to minimize the impact of any of those.

Our mission is to provide the finest caliber prehospital care and essential life support that we can. I would say that the assumption that, first of all, somehow the District government is not awake, that we have not been focusing on this issue, is inaccurate, to say the least. We have medical supervision on the street every day.

I don't think it is accurate or fair to the individuals who provide the service to categorize them as being the subject of on-the-job training. Most of the individuals who provide this service through the EMT, intermediate paramedic and paramedic levels have to subject themselves to a rigorous training program to get certified for intermediate paramedic and paramedic, and have to work very hard in classroom and at work environment to keep themselves qualified, and to carry cards at the intermediate paramedic and paramedic level; and I'm proud of their professionalism.

The question about fire department management: If, as the media says, the Baltimore system is one of the finest in the country, it works within the fire department, and if you are able to tap the resources that are there in the fire department the way the Baltimore system does by having trained EMT firefighters on the company—they're there for backup, for manpower assistance, for first response stabilization, close coordination if that close coordination is there and available. The system works much better. That is the rationale for having the service within the fire department.

I know we could have endless debates about the residency requirement. It is the law in the District. It is a requirement that we have lived with successfully in both police and fire recruits. We've had several thousand people turn out for firefighter exams, police exams, for prospective 200 positions. So that we have not had a problem in the recruitment side.

To say that the individuals who were selected in the ambulance service are simply not qualified is demeaning to them, and our

challenge is to make sure that the school system and our training programs provide the finest qualified strain of individuals that are necessary for this system. They are there. We are in the process of recruiting and training them. They will continue to be there.

The last point that I want to make about response time, about blue smoke and mirrors, Mr. Parris' point about simply trying to change the method of computation. The reason that we did that is that we were constantly being measured by the media and by the Congress and by a number of other individuals with our suburban neighbors, with our suburban jurisdictions, with Baltimore and several other jurisdictions.

We had the broadest definition of response time of any jurisdiction in the area. In surveying Arlington, Alexandria, Fairfax, Montgomery, Prince George's, Baltimore and several other jurisdictions in this area, which we were being compared to, that is how they all measure their response time, from the time of dispatch to the time of arrival. The change was to allow for comparisons within this region of what real response time is. It is now 6.8 minutes on average, and it is dropping every—our response time is dropping every month.

To say that the 3 minutes that were changed because of a change in the method of computation is both unfair and inaccurate—There were real gains of a minute and a half in simply management improvements in response time and allocation of resources. We said we would continue to be measured both by the old method of measuring response time and by the new method, so that there would be at least the capability of comparing what was happening in the systems.

We've continued to do that, provided that—continued to provide that information. Our response time is dropping. It is dropping significantly. It is not where we want it yet, although it is getting comparable with—It's getting to a comparable point with Arlington and within about a minute of Fairfax County. So we're getting closer.

We are not satisfied with that, and still would like to have the lowest response time in the region. We will have that.

Mr. Chairman, that concludes my remarks. I'll be glad to answer any questions you may have.

[The prepared statement of Mr. Downs follows:]

Testimony of

Thomas M. Downs
City Administrator and Deputy Mayor for Operations

before the

Subcommittee on Fiscal Affairs and Health
Committee on the District of Columbia
House of Representatives

Wednesday, August 5, 1987

Good Morning Chairman Fauntroy and members of the Committee. I am Thomas M. Downs, City Administrator and Deputy Mayor for Operations of the District of Columbia Government. I am pleased to appear before you on behalf of Mayor Barry to provide testimony to your committee on the operating status of the District's 911 emergency telephone system and its emergency ambulance service.

ENHANCED 9-1-1 EMERGENCY TELEPHONE SYSTEM

It was in 1969 that the District, through the Metropolitan Police Department introduced the 9-1-1 emergency phone system to the public. Since, the system has been used millions of times. In fact, the original 9-1-1 was so popular that it soon became overloaded by request for services in addition to emergency calls. By 1985, the 9-1-1 emergency system was receiving in excess of one million calls per year.

It was also in 1985 that the old electromechanical system was beginning to be off the air more than it was on and replacement of the system became inevitable. Before installing the new 9-1-1 system, the Mayor ordered an analysis of the calls being received on 9-1-1 to assure proper utilization of any new system for emergency calls. It was determined that of the more than one million calls received each year, 450,000 were non-emergency in nature.

Consequently, at the direction of the Mayor, the Office of Emergency Preparedness developed the "8DC-HELP" system a much publicized citizens' information and referral system whose primary purpose is to relieve the emergency 9-1-1 system of non-emergency calls. Citizens who need assistance from the District Government, but who do not need the immediate dispatch of a police, fire or ambulance vehicle, now have an alternative number to 9-1-1 to call for help.

The District's 9-1-1 system, working in conjunction with "8DC-HELP" to respond to all citizens' requests for assistance, is one of the most comprehensive systems in the Metropolitan region, If the 9-1-1 system receives a call that does not require the immediate dispatch of a police, fire or ambulance vehicle, the 9-1-1 operator transfers the call to "8DC-HELP". Similarly, if "8DC-HELP" receives a call that represents a true emergency, it will immediately transfer the call to 9-1-1. As far as can be ascertained, the District is the only jurisdiction in the nation that has come up with a viable alternative number to 9-1-1 for citizens to call in non-emergency situations.

At present the District operates a fully enhanced and highly sophisticated 911 Automatic Call Distribution System. This system has two proven lifesaving features; Automatic Number Identification (ANI) and Automatic Location Identification (ALI). The installation of the system has drastically decreased the average wait time on 9-1-1. The system further improves emergency response time by automatically channeling incoming calls to the next available operator on a first-call, first-served basis. During peak call hours, a delay announcement alerts callers to the fact that they have reached the emergency police, fire and ambulance number and that their call will be handled promptly. Calls are now answered in 4.8 seconds on the 9-1-1 emergency system.

The Enhanced 9-1-1 system is also a management information system providing statistical information useful for staffing and planning purposes. The digital display for the operators, gives a visual number of calls held in queue, prompting the necessity to speed up call taking to ensure rapid response to incoming calls. Through the use of ANI, which is a display of the telephone number from which a call is being placed, and ALI, a display of the location, type of telephone service, (i.e., pay phone, centrex, residence and/or cellular user), and the name of the person under which the telephone is listed, the police have been able to make several arrests for various offenses.

Over the past few months, the 9-1-1 system has been inappropriately identified in the media as experiencing many problems. Nothing can be further from the truth. Indeed 9-1-1 is alive and functioning well. What has been the case is that whenever a problem occurs in the delivery components of the 9-1-1 system - ambulance, fire or police, the media lumps all of these situations as faults with the 9-1-1 emergency telephone system. This has had a devastating effect in that people have begun to believe that the problems are all associated with the phone system itself, rather than with component delivery units. One immediate reaction has been the practice of having the operator place the call to 9-1-1 for an individual rather than the individual calling for themselves. There are two immediate impacts: one is the obvious and unnecessary delay of first getting the operator who then gets 9-1-1; however, the other, and far more serious impact, is that we lose the capability of getting critical information which can result in loss of life. If, for example, prior to providing necessary location information to the operator and/or the 9-1-1 call taker, the party is disconnected for whatever reason, we no longer have the capability to automatically dispatch emergency units because we have no idea where the call originated. Such calls are alarmingly on the increase and negates the most outstanding feature of Enhanced 9-1-1 (ANI/ALI information).

In an effort to combat this problem and other problems of proper projection of the 9-1-1 emergency phone system to the public, the Metropolitan Police Department, the Office of Emergency Preparedness, the Fire Department and the C & P Telephone Company have joined forces to launch an extensive public awareness campaign on the true benefits and features of our 9-1-1 system and to encourage the public to continue to use 9-1-1 whenever they are experiencing true emergencies.

Since the installation of our Enhanced 9-1-1 System and 8DC-HELP, the results and benefits have surpassed our greatest expectation. We feel we have a system second to none in this nation.

EMERGENCY AMBULANCE SERVICE

The Fire Department first became involved in the delivery of emergency medical care in 1928, with the provision of limited first aid care to citizens suffering from breathing difficulties and heart attack symptoms. In 1957, the District formally established the Emergency Ambulance Service to provide first aid treatment to citizens. During the 1960's and 1970's, federal legislation improved pre-hospital emergency care nation-wide, providing emergency vehicles and equipment, radio communications, and training programs for both medical technicians and paramedics in communities. Currently, this service is being provided by the Fire

Department, first with uniformed firefighters and more recently with civilian personnel.

Since the Emergency Ambulance Service provides pre-hospital care, a basic involvement with the medical/hospital community is essential, resulting in heavy involvement by components of the Commission of Public Health on the regulatory and training aspects of the program.

To better understand the operation of the District's emergency ambulance service, let us look at our system in comparison with other major U.S. cities and the jurisdictions in the Washington Metropolitan Area. In June 1987, in response to public criticism of the District's emergency ambulance service, my productivity management staff conducted a survey of the thirty (30) most populated U.S. cities, in addition to metropolitan area jurisdictions. The survey consisted of twenty-one detailed questions directed at response time, incident volume, resources, and operations. While not a scientific study on which definite resource allocations or operational decisions should be drawn, the study was sufficiently structured to allow comparison. The District ranked:

(1) 9th among 29 cities in response time. Ambulance response time has a variety of components that contribute to the time it takes to respond to an emergency medical situation. Most jurisdictions start the clock when the ambulance is dispatched and stop the clock when the ambulance arrives at the scene. For the purpose of this survey, response time refers to the time measured from dispatch to ambulance arrival on the scene.

(2) 2nd highest among 30 cities in the number of ambulance incidents per 10,000 population. DC's rate of 1649 incidents per 10,000 population was almost double the city average of 870 incidents. Only St. Louis ranked higher with a rate of 1700.

It should also be noted that Washington Metropolitan Area jurisdictions showed a lower average number of incidents per 10,000 population when compared to major cities with an average rate of 679 versus 870 for cities surveyed.

(3) 21st of 24 cities when comparing the ratio of call takers and dispatchers to incidents.

The average was 0.8 operators per 10,000 incidents which is more than double DC's 0.3 operators. This has recently been approved with the hiring of fifteen (15) additional dispatchers.

There were other interesting items brought out in the survey; however, the above serves the purpose of setting the scene for discussion of our emergency ambulance system. One would believe from reading the newspapers and looking at television that the District's ambulance service is the worst in the nation. While we do concede that there are problems in our system, they represent no more nor less than those experienced by other cities. Similar problems are occurring in New York City and Chicago. For example, the response time in New York City is 13.8 minutes. Moreover one reads that the objectives of the Phoenix System is to "shoot" for a response time of to minutes within the city boundaries.

To be sure, the District's goal is to have one of the finest systems in the country - a goal set by the Mayor and shared by the Fire Chief and Commissioner of Public Health. What is essential in any discussion of our emergency ambulance system is to understand that while problems have occurred in excess of 10,000 runs a month, or 120,000 per year, are being made completely without incident by the dedicated personnel in our ambulance, firefighting and communication services.

To be sure there are problems to be addressed, some of which will require more money, additional personnel, more and better training and better management. However, the Mayor has established a framework within which all of these problems are being addressed and progress has and will continue to be made. As earlier stated, the resolution of these problems will require great cooperation from the medical community, the hospitals and the general public. To that end, the Mayor has restructured his Emergency Medical Services Advisory Committee (EMSAC) to assure direct representation of all segments of the community on this important committee. New members were sworn in on July 22, 1987, and organizational proceedings are underway.

Approximately one year ago, a task force commissioned by the previous EMSAC issued a report quite critical of the operations of the emergency ambulance service which received mixed reviews, particularly from the Fire Department. Notwithstanding these disagreements, this report has subsequently served as a

basis for understanding the problems and concerns confronting the delivery of emergency ambulance service. The Mayor has appointed a continuing work group at the highest levels of this government, including the City Administrator, Fire Chief, Emergency Preparedness Director, and Commissioner of Public Health, to deal with the concerns of that report and to identify (and correct) any other problems related to improving the system.

The working group has met with ambulance personnel and the unions representing them, (CWA Local 2336, AFGE Local 3721 and International Association of Firefighters Local 36) as well as medical/hospital personnel, and has drafted a plan of action to address the totality of concerns about the system. These concerns are summarized on a computer generated "Issue/Resolution" report which is constantly updated as to progress made on each.

Some of the major improvements in the city's system for the delivery of emergency ambulance services that have been made by the Mayor's working group include the following:

(1) The ambulance service has been elevated to the Bureau level headed by an Assistant Fire Chief. This improvement means that the unit now reports directly to the Fire Chief. As has been reported, the District is actively seeking a civilian expert in the management of delivery of pre-hospital care to head this Bureau. Once selected, he/she will remain at the Assistant Fire Chief level and report directly to the Fire Chief.

(2) Medical oversight and monitoring, which is so critical to the maintenance of high caliber delivery of pre-hospital care, has been assumed by the Commissioner of Public Health. Media reports notwithhstanding, this is a cooperative arrangement with the Fire Chief and the Commissioner of Public Health, and great progress has been made in this area. This includes daily medical review meetings in which the ambulance run sheets and unusual occurrence forms are medically reviewed and recommendations for corrective actions passed on to the Fire Department.

(3) All firefighters are being trained to the EMT level and within a few weeks all 33 engine companies will have at least one EMT assigned to it. Additionally, over 1,000 firefighters have received CPR training.

This means engine companies are and will run medical locals putting an EMT trained firefighter on the scene within 2 to 3 minutes to begin the critical stabilization of patients.

Moreover, during those times when no ambulances are available, the city's four Rescue Squads will be dispatched to the scene, with an EMT trained firefighters on board. These units will provide transportation to the hospital if an ambulance is still not available.

(4) Serious problems with radio communication have been addressed and by mid-September significant improvements will be in place to include providing another channel in the ambulances and better portable radio communications.

(5) All authorized dispatcher positions have now been filled, and an additional nine (9) dispatchers will be hired which will provide for two additional workstations on the floor. Parenthetically, we would like to emphasis that the District has experienced no difficultie in recruiting for police or firefighter positions. We fully expect that once all recruitment processess are in place for the emergency ambulance service and communications, our record of success will match that of the one achieved in the public safety categories.

(6) A mental health counselor has been hired to provide stress counseling and support to ambulance, dispatcher and firefighter personnel who run medical locals.

(7) Twenty-one ambulance units have been placed in service with five (5) fully staffed units kept in reserve for ready replacement when and if needed. In furtherance of this goal, the maintenance function within the Department has been expanded to 24 hour operation.

(8) An entirely revamped training operation is being developed to address:

a. adequate number of in-house training staff.

b. development of supplemental training resources at the University of the District of Columbia and within the Medical Consortium.

c. training programs for EMT, intermediate paramedic (IP) paramedic (P) and medical dispatchers.

9. All dispatchers, EMT, IP, and P positions will be recruited without limit to assure a proper pool of capable personnel at all levels, at all times.

10. All personnel providing medical care of any type are subject to medical review:

    a. ambulance personnel and Rescue Squads will fill out the ambulance run sheets which are then reviewed by the medical officer.

    b. firefighter EMT's responding to medical locals will fill out a Patient Assessment Form indicating any care provided prior to arrival of the ambulance. These forms are attached to the ambulance run sheet for that incident and provided to the medical officer.

    c. all personnel fill out unusual incident reports (including dispatchers) which are provided to the medical officer.

11. A thorough review of the priority dispatch system is underway with new medical protocols having been developed. While we recognize the great work that Dr. Clawson of Salt Lake City has done in the field of priority dispatching, the District's new medical protocols have been developed with the full input and cooperation of our medical community and approved by the EMSAC. They will, therefore, be the protocols used with our system.

For additional improvements to our system, these additional longer range programs will be implemented:

1. Replacement of the fire department's radio system with a state-of-the-art 800 Mhz Trunking System.

2. Replacement of the existing computer assisted dispatch system (CAD), originally installed during the 1970's with today's state-of-the-art.

3. Development of an apprenticeship program in the DC Public Schools in the area of emergency medical service to include medical dispatchers.

4. Provision of in-field evaluators for proper evaluation of all EMT's IP's, P's and fire-fighters EMT's.

5. Development of alternate methods of non-emergency transportation.

6. Installation of an automative vehicle locator system to include digital entry of "on-scene", "at hospital" status.

7. Development of a permanent high level review committee to monitor and review the operation of the Emergency Ambulance Service.

In conclusion, Mr. Chairman, the District is committed to the development of the finest fire emergency ambulance service in the country here in the Nation's Capital. We admit problems have existed; however, they are not of the magnitude one would believe from media attention of the past few months. While any service that deals with human life but definition must strive for absolute perfection, one must recognize that human and mechanical errors will occur. We cannot state that they will not occur here. On behalf of the Mayor, we can emphatically state that we will not tolerate flaws in our system. In fulfilling its mission of providing high caliber pre-hospital care, all essential resources, including manpower, equipment, training and management support will be made available to the Fire Department.

I thank you for this opportunity to appear on behalf of the Government of the District of Columbia and I will be pleased to respond to any questions you may have.

Mr. FAUNTROY. I thank you, Mr. Downs, for not only a very thorough testimony in your written statement but with a very comprehensive summary.

In your testimony, you indicated that as late as 1985, nearly half of the calls received on the District's 911 number were of a nonemergency nature, and that was before you implemented the 8DC–HELP system. Do you have any information as to the percentage of nonemergency calls that are now coming in, in light of that change?

Mr. YELDELL. Mr. Chairman, that has dropped from about a 50 percent factor to roughly around 42 to 43 percent. I might also say that in the area of the use of a police administrative number, that decrease has been about 40 percent in just that one number alone. So 8DC–HELP has begun to take hold. We have a lot more to do to advertise it, but it's working.

Mr. FAUNTROY. How long has it been in effect?

Mr. YELDELL. We implemented it in December of 1985 on a trial basis. We paralleled the implementation of the enhanced 911 in April and May, and went to full-scale operation 24 hours a day.

Mr. FAUNTROY. All right. Have you considered any further improvements in the 8DC–HELP system so as to divert more of the nonemergency calls? For example, have you looked at the prospect of having, say, an 811 number?

Mr. YELDELL. Yes, Mr. Chairman. We looked at the prospect of using a three digit number for nonemergency purposes. However, it is against the practices of the telephone company to allocate three digit numbers unless they have the same universal application. So our request for a three digit number was denied. That's why we went to the acronym for the 8DC–HELP process.

I think what is necessary is to recognize it took many, many years to successfully get the public to use 911. What we are trying to do with an aggressive public information campaign, is to make the public as aware of 8DC–HELP as they are of 911.

I would also point out parenthetically, Mr. Chairman, that the second largest percentage of calls to 8DC–HELP come from nonresidents rather than from residents. The highest usage of it is in ward 3.

Mr. FAUNTROY. The management information component of your system, you say, aided in the—has aided in the police making arrests. Have those arrests been related to abuse of the system and, if so, are laws currently on the books that deal with that situation adequately?

Mr. DOWNS. Mr. Chairman, those referred to malicious or intentional false reports given to the system, bomb threats, threats on life or property, erroneous reports entered into, say a shooting in an alley or something, where there was none. The number that that call was made from automatically registers on the screen within the D.C. Metropolitan Police Department and is stored, as does the address and the—the name and address of the owner of record of that phone. It will show every phone whether it's listed or not, pay phones, information phones, whatever. Anyone who makes a call into this system will have an automatic number identifier and an automatic location identifier registered within the police department.

It has led to a reduction in the number of malicious or prank calls into the system. We have a followup system in the police department where an officer, if there is a single serious call or a pattern of calls, an officer will do a personal followup with the individual who owns this phone at their home.

Mr. FAUNTROY. You mentioned in your testimony a number of comparisons. You made reference to comparison with Fairfax County and with Baltimore. Could you be more specific as to what the information is on the comparative performance?

Mr. DOWNS. In terms of response time, Baltimore logs its response time from the dispatch to the first unit on the scene, which—if it is a fire unit, they log that as their total response time. In other words, the first EMT on the scene stops their clock. They have a response time of about 3.6 or 3.7 minutes. If we logged ours the same way, we would probably have about approximately the same, but we do not. We run it until—right now, until the first ambulance unit is on the scene.

The Fairfax County figure is about 5.8 or 5.9 minutes on response time, and it is from dispatch to arrival on scene. I think Arlington, if I remember, is about 6.1 or 6.2 minutes and is calculated the same way.

Mr. FAUNTROY. And how does that compare to ours? I mean, what are the comparisons?

Mr. DOWNS. Our comparison is 6.8 minutes for response time from time of dispatch to arrival on scene.

Mr. FAUNTROY. And Baltimore, you say——

Mr. DOWNS. Logs their response time to the first engine—fire engine company with a EMT on board, not from the time of the first medic unit or ambulance unit arrival.

Mr. FAUNTROY. Some have argued that the District emergency ambulance service should not be under the fire department. What is your response to that?

Mr. DOWNS. The systems that we've looked at around the country that seem to have the best prospect for a quick response time are those that are fully integrated within the fire department. The tensions that are there, we found in other systems as well, between civilians and uniforms, that there is a difference—perceived to be a difference in status between the systems, and that's a problem. All the other cities admit that they've had problems in that area.

The gain for the public—That's a management challenge, though. That's not something that the public has much tolerance with. Issues of turf and status are not what the public has in mind. The public seems to be best served by having a fully coordinated set of trained individuals who provide this service quickly as backup to each other. That means a fully coordinated communications system, priority system, and chain of command.

If a fire unit is first on the scene and it turns out that there is no one there, which happens in a surprising number of cases, or that there is no need for an ambulance, the fire company can turn the ambulance around and head it back to the station so it's ready for another call. They can provide the extra manpower to drive a unit when both paramedics have to be in the back working on a patient, which happens a lot on priority calls. They can provide the extra manpower that is necessary to move people in high rise buildings,

and so forth. They can provide—They can help provide a number of services and help each other a lot in this system.

The value that the city has placed on that is very high, but again we know we have problems between unions, between civilians and uniforms; but those are not acceptable to us, and will have to be worked through.

Mr. FAUNTROY. Let me finally ask on this round: You've given us comparative figures with respect to response time. Do you have any comparative information on how the District ranks with other jurisdictions in terms of training and preparation of all personnel involved in the emergency response system?

Mr. DOWNS. I think it's fair to say that our state certification system for cards—for EMT cards, for intermediate paramedic and paramedic cards, are as stringent as any jurisdiction that we looked at. Our training requirements are as stringent, and our staffing requirements for designation of paramedic units, in other words, two paramedics per unit, is as stringent as any jurisdiction.

Some areas like Baltimore have a paramedic unit with one EMT and one paramedic. Here, for a medic unit we have two paramedics. Our standards are strict. Our training program has had some tensions within it between the hospital consortium and some other providers, the University of the District of Columbia. We think we've resolved those or are well on our way to resolving those kinds of tensions in the training provision side.

Mr. FAUNTROY. You heard Mr. Parris' reference to the fact that more than 1,400 members of the fire department have no CPR certification. How does that compare?

Mr. DOWNS. First, I think it's inaccurate. Chief, do you want to answer? I do know that card carrying, CPR qualified firefighters—I think there are over a thousand currently carrying CPR cards. As I said, we had at one point up to, I think, 600 firefighters who were EMT card carrying certified. A decision was made to go to a first responder certification. That was probably a mistake. We should have stayed with full qualification at EMT level for as many firefighters as we could. But I do know that over 1,000 firefighters are currently card carrying. Chief?

Chief COLEMAN. That is correct, Mr. Chairman. We have been working diligently to ensure that the firefighters in the District of Columbia Fire Department firefighting division are certified CPR trained individuals. Of course, that number that Mr. Parris mentioned about 1,300 and some firefighters—We have 1,271 firefighters as related to our staff at this time.

Mr. FAUNTROY. Thank you, and I yield now, my time having expired, to Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman. Mr. Downs, how many calls a year do you process?

Mr. DOWNS. The EAB has requests for over 10,000 calls per month, roughly 124,000 calls for service per year.

Mr. BLILEY. And how many 911 operators do you have on duty at all times?

Mr. DOWNS. The difference between the 911 operator in the central 911—We have at central 911—Joe?

Mr. YELDELL. We have 18 stations, and it's staffed with about 13 persons on an average. That's at the police point of—first point of

contact. They are then transferred to fire where we have medical dispatchers who take the call.

Mr. DOWNS. Medical dispatch is probably more germane to the concern, in that we have nine.

Mr. BLILEY. On duty 24 hours a day?

Mr. DOWNS. That's correct.

Mr. BLILEY. How many ambulances do you have on duty at any one time?

Mr. DOWNS. We run all of our ambulances 24 hours a day, 365 days a year shifts, so that there is no fluctuation in the numbers. The five medic—advanced life support units. The remainder are basic life support units.

Mr. BLILEY. How many of those?

Mr. DOWNS. Sixteen. A total of 21 units, 16 basic life support, 5 advanced life support.

Mr. BLILEY. Do you have digital phone equipment now as opposed to electromagnetic?

Mr. DOWNS. I'm sorry?

Mr. BLILEY. Is your equipment, telephone equipment, now digital, or is—on a digital system, or is it electromagnetic?

Mr. DOWNS. At the phone switch—the dispatch area?

Mr. BLILEY. Yes.

Mr. DOWNS. We're all digital.

Mr. YELDELL. If you're talking about the 911 system itself, yes, it's digital. It's electronic. Electromechanical equipment is gone.

Mr. BLILEY. So you have—When the call comes in you, I believe, stated, Mr. Downs, that you have a record of the number of the address and the owner?

Mr. DOWNS. Automatically recorded off the data base, yes.

Mr. BLILEY. Your emergency personnel who operate these vehicles—Do they have liability insurance provided by the city?

Mr. DOWNS. We're a self-insured jurisdiction. It's part of our budget. We have a claims and liability budget within our regular District budget. We do not—We self-insure. We do not—We provide that coverage for them, but we are a self-insured jurisdiction.

Mr. BLILEY. I would gather, because of the problems with liability insurance generally for municipal governments, this would be true of your neighbors, Fairfax, Arlington, Baltimore and the like?

Mr. DOWNS. I think the larger jurisdictions in this region are self-insured for most of their liability coverage.

Mr. BLILEY. Thank you very much. Thank you, Mr. Chairman.

Mr. FAUNTROY. I thank the gentleman. Mr. Parris?

Mr. PARRIS. Mr. Chairman, I notice that there is a vote on the floor. Let me just make a couple of quick observations, Mr. Chairman, with your permission. We'll run to meet that, and I'd like unanimous consent to pursue my questioning upon return. We'll be as quick as possible.

Mr. FAUNTROY. As the gentleman notes, he will go to vote even though he represents less taxpaying residents than I, and even though I represent more taxpayers than any single Member of the House; for that reason, not only am I going to allow him to question up to that point, but I'm going to double his time and, when he comes back, he may take as long as he wishes to query the witnesses.

Mr. PARRIS. You will recall, Mr. Chairman, I've taken issue with your characterization of that in the past, and I won't take the time of these ladies and gentlemen to do so again.

Let me just make several quick observations. First, let me read to you, ladies and gentlemen, from the Emergency Medical Service Advisory Committee Task Force Report dated May 1986, your report prepared by your task force; and it says under paragraph 2, training: "Of the 1,494 firefighters in the District of Columbia Fire Department, only 34 have current EMT certification. None have first responder; 90 to 100 percent lack CPR certification."

In the executive summary under roman I, training, page 5—page 4, excuse me, it says: "1,494 firefighters do not have current CPR certification." That's from your task force report.

To me—again, stated categorically, I do not believe that it contributes to the purposes of this hearing to take a cheap shot at Fairfax County and its 911 problems. They recently engaged in the computer transfer program. They had some temporary problems with telephone lines. We all acknowledge that. We all regret it. They, I'm informed, are now—have been or are now being corrected.

Just for the accuracy of the record, Mr. Downs, let me suggest to you that I did not characterize and do not now suggest that all the current personnel in the District of Columbia Emergency Medical Service are engaging in on-the-job training. That's not what I said.

I stated that the Emergency Medical Service must not be permitted to become an on-the-job training situation. That's what I meant, and that's what I said.

With those observations, Mr. Chairman, I will return from the floor at the earliest time. Thank you.

Mr. FAUNTROY. All right. The gentleman—I will continue the questioning, but will ask the panel to prepare to respond to the questions about——

Mr. DOWNS. About Fairfax County.

Mr. FAUNTROY [continuing]. Fairfax County, and about the level of CPR trained technicians which is, of course, also a concern of mine; but I want you to answer that in the presence of Mr. Parris.

Let me pursue a couple of questions inasmuch as, while I represent more single members—more taxpayers than any single member of the House, I do not have to go to the floor to vote. I can continue these hearings and keep the record open as we await their return. We hope that, with the cooperation of some members, that situation will change in a couple of years.

I wonder how near you are now to hiring a civilian expert to head the ambulance emergency service.

Mr. DOWNS. Mr. Chairman, every time I give a date and it passes, I have numerous journalists standing on my doorstep saying, why did you miss Friday. I've learned since that, in the process of doing a national recruit like this, you have to work around other individual schedules from around the country. We've had individuals scheduled in from the west coast and from the Northeast and the Southeast. We have to work around their vacation schedules and their own governments' requirements of them. In some cases, we've had trouble scheduling them.

I fully expect in a relatively short time to have a name to announce for service. Because this depends so much on a number of other individuals and their schedules, I have found that it's best to be rather conservative about that, but I am very optimistic about the relatively near term.

Mr. FAUNTROY. The relatively near term.

Mr. DOWNS. Mr. Chairman, very soon.

Mr. FAUNTROY. Weeks? Months? Years?

Mr. DOWNS. Weeks.

Mr. FAUNTROY. All right. Is there a system in place, or will there soon be a system in place to assure accountability from the emergency ambulance service, other than citizen complaints as a barometer? For example, is there a monitoring and tracking system for each response by an ambulance?

Mr. DOWNS. There is both an enforcement provision about an unusual—any unusual incident occurrence, which is a very broad definition. If there is a problem with an individual on the street with an intermediate paramedic or an EMT or any personnel within the service, there is supposed to be an unusual incident report filed. The supervisor is to review it, and Mr. Yeldell coordinates the response—or the review between the fire department and the D.C. Commission on Public Health.

Corrective action, whether it's training or discipline or education of whatever kind is then prescribed for that incident. The EMS—The revised and expanded EMS committee which now includes representatives from the unions who are providing—engaged in providing parts of this service will also be reviewing the issues of quality of service, quality of care and making ongoing recommendations about improvements in the service.

We fully intend to be responsive to those concerns as well.

Mr. YELDELL. Mr. Chair.

Mr. FAUNTROY. Yes, Mr. Yeldell.

Mr. YELDELL. Just to expand on that, I think in terms of the thrust of the question, every ALS, every advanced life support run sheet is pulled daily for medical review. One-third of the basic life support units' run sheets are pulled daily for medical review.

In addition, any engine company that responds on a medical local—They will fill out a patient assessment form which is then given to the ambulance that also responds, and that is attached to the ambulance run sheet. It is also reviewed.

If a rescue squad goes out on an ambulance run, they must fill out the same run sheet as the ambulances, and they are also subject to medical review. Finally, as Mr. Downs has said, the fire department is in the position now of hiring in field evaluators who will be in the field each day monitoring the entire ambulance operation, whether it's from the ambulance—from the engine companies or the rescue squads.

Mr. FAUNTROY. So that we are not relying solely on citizen complaints, but that there is a monitoring and tracking system applying to each ambulance response.

Mr. YELDELL. That's correct.

Mr. FAUNTROY. All right.

Dr. COLEMAN-MILLER. Mr. Chairman, to further expand on that, under the direction of the commissioner on public health, Dr. Tuck-

son, and often with Dr. Tuckson presiding in the meetings, on a daily basis we meet every morning and discuss any compromised prehospital care with the fire department and the emergency ambulance division.

There is also an opportunity for the fire department to have continuing medical education as a result of that compromised health care. We have created a library for the emergency ambulance bureau. We speak to the personnel individually. If we find a problem that is especially compromised, we inspect their ambulances. We investigate their unusual occurrences very closely. So that there is very close monitoring at this point.

Mr. FAUNTROY. Can you share with us the day to day, hour by hour command structure of the emergency ambulance system? I'm especially interested in learning about the kind of supervision available to the emergency response personnel, the emergency technicians. What's the picture like each day and each hour?

Chief COLEMAN. Mr. Chairman, thank you for this opportunity. Every day, upon assuming duty, at this time we have an assistant fire chief who is in charge of the day to day operation of the ambulance bureau. However, in the same office, to give greater management, we have one deputy fire chief and two battalion chiefs.

In addition to that, we also have supervisors and chief supervisors who also work in that capacity monitoring the process and exemplifying management control as it relates to the ambulance crew in the field. So there are many supervisory techniques used in the ambulance service to ensure that the citizens get the appropriate service out in the field.

Mr. YELDELL. Mr. Chairman, also, I think one of the other factors we want to point out here is that has also been one of the concerns highlighted in the monitoring. We now have two civilian supervisors per shift. That has now been authorized to go to 4 supervisors per shift, which will in fact double the number of total supervisors from 8 to 16 to assure that there is better supervision in the field.

Mr. FAUNTROY. They can, therefore, be in hourly contact with emergency technicians for purposes of supervision?

Mr. DOWNS. That is correct.

Mr. FAUNTROY. One area of controversy is whether a system of prioritizing calls ought to be put in place. What is your view on that, and what does the District now do with respect to prioritizing response to calls?

Mr. DOWNS. Mr. Chairman, first of all, I think it's—There is a misapprehension about the fact that some jurisdictions apparently do not prioritize calls. For instance, they say they do not have a priority system in Baltimore, but in effect they do. They simply don't call it a prioritization for calls.

When you get 124,000 or 125,000 calls each year and only 60 percent of them wind up being anywhere close to a medical emergency on the scene, you wind up with 40,000 to 50,000 calls that may be not necessary for any type of medical response: No individual on scene; it is a nonemergency transport, or they simply wanted a way to get to the hospital, et cetera, or a doctor's appointment or a pharmacy. When you wind up with that number of calls and that many people in the District who depend on the emergency medical service, you have to make some decisions about allocating priority.

There is a difference between a sprained finger and a heart attack. Everybody on the street will recognize that, and you have to make some judgments. How long it takes to establish that priority and how complex it is is, what is really at issue.

We recognize on the front end that our priority dispatch setting procedures were too complex. They were too detailed. They were trying to get at too much information on the front end of a call. Everybody agreed that they needed to be simplified, and they have been through a review process involving both the hospital based providers and the dispatchers.

We hope that we have the right balance between the need to distinguish between a nonemergency call and the need to have a very timely response. We have a system that I think is tailored to the uniqueness of Washington, in that, if we have the second highest number of calls per capita, we have a service that is trying to respond apparently to a large number of nonemergency calls that are inappropriate; and we have to establish some kind of priority system.

I think we've struck the right balance, and we're willing to try it for a period of time and see if that's true.

Mr. FAUNTROY. I am reserving for Mr. Parris followup on the questions dealing with the report which he referenced, but I am interested in the number of people trained in CPR and certified for that. Can you give me that specific figure, compared to what was reported in the reference made by Mr. Parris?

Mr. DOWNS. First of all, the report lists an untrue number of authorized firefighters. As the chief said, he's got a current on board strength of 1,271. That's the total strength in the fire department, not 1,400.

The second is that report was over a year old, and the differences between his numbers and now—or we can celebrate history, to some extent—may have been accurate at that time. There are currently over 1,000 card-carrying firefighters with a CPR card, according to our certified records on the issuance of cards. That training has been provided in that period of time.

Mr. FAUNTROY. I'll ask that that be repeated; but you're telling me that, contrary to the report of a year ago, that of 1,434 members of the fire department not a single one had CPR certification, the fact is, of roughly 1,200, 1,000 have certification?

Mr. DOWNS. That's true.

Mr. FAUNTROY. My——

Mr. YELDELL. Mr. Chairman, I think it's reflective of the fact that the District has used the report to move forward. Training has taken place since that report was issued, and there is a program underway to train all firefighters to CPR-level training.

Mr. DOWNS. I think Mr. Parris may have created an untrue impression when he stated that the report was put on the shelf and never looked at again. We have taken a significant number of actions to correct some of the deficiencies that were pointed out. In those areas where there are conflicts with other reports and other professionals' recommendations, they've been harder to work out.

Mr. FAUNTROY. I wonder if you could share with the committee the—a few of the 137 recommendations that you said you've ac-

cepted that run to concerns that you know citizens to have raised around the whole emergency ambulance service system.

Mr. DOWNS. Since Mr. Yeldell monitors that on a daily basis, I'll ask him to respond to it.

Mr. YELDELL. Mr. Chairman, what we basically did was to gather data from the reports, meet with the union representatives, and indeed with health officials, and come up with a master list of concerns that must be addressed to perfect an ambulance service that would give the quality of care that we are looking for. Among the items that were addressed in that report that we constantly monitor, it's first of all medical supervision. That is one of the key issues that is of concern to our own health commissioner and, obviously, to the hospitals who ultimately provide the emergency care in the hospital.

We divided the report into a management section, a personnel section, a training section and a medical review section. Each of those elements have varying numbers of items that are monitored constantly. All of the data has been put into a computer, and we go through and update the process approximately every 2 weeks.

On the management side we are looking at the realignment of the emergency ambulance bureau. One of the first steps, as Mr. Downs has mentioned, was to elevate the ambulance operation from a division within the field operations bureau to a bureau status of itself. Other things that we have dealt with in the management side is to look at how we actually provide services and monitor whether those are improving at all.

On the personnel side, we are looking at the relationships of the people working in the unit, such as how do we deal with the level of entry into EMT, whether or not we hire persons who are certified already in IP and P, and the position descriptions for each of those.

For example, in the EMT level, one of our problems we found was that the original description required 4 years of experience to even be considered for an EMT; whereas, on a firefighter all you had to do was have the aptitude to be trained. That, therefore, has been changed; and that's the way we are addressing the EMT process. As Mr. Downs has mentioned, we are now prepared to hire certified IP's and P's, intermediate paramedics and paramedics.

The training side is one of the areas where we recognize a major problem, and it's one of the things that we are monitoring constantly. We now have a problem of getting our dispatchers trained. We will be doing some inhouse training, but we're going to need additional resources to get that done. We are looking at those elements as well.

One of the other processes was the input of data and the utilization of that data to actually make additional changes to the system. We have modified the kinds of reports that we generate from the computer that exists. As Mr. Downs has also mentioned, we recognize that the computer that is used to assist us in dispatch is entirely antiquated and must be replaced. That will be monitored. We will be issuing an RFP to get that in-house.

Fundamentally, the major concern that we are dealing with at this point is radio communication and its capability, including telemetry between the ambulance and the hospital. So we are now

looking at implementation of a totally new technology of 800 Mhz trunking. That is being monitored.

In the interim, we found that there were things that could be done to give us a quick fix on some of our radio problems. For example, once an operator left the ambulance, portable communication was almost nonexistent. We are now in the process of installing in the ambulances new mobile radios which have repeater capability in the mobile itself, so that when the operator leaves the ambulance and takes his or her portable, they will now have portable communication between each other and the hospital as well.

So those are the kinds of things we are doing, monitoring each of the steps that are necessary to iron out the bugs and develop an emergency medical service that we'll all be very proud of, and then to set that monitoring process in place to go on as the system operates.

Mr. FAUNTROY. Thank you so much. It's obvious that the advisory committee did exhaustive work and that you in response are attempting to implement the—many of the recommendations that have been made.

I'm going to ask, if you do not mind, if you would return to your seats and be prepared to respond to Mr. Parris' queries when he returns.

In the meantime, I would like to ask the distinguished council member from ward 8 and Chair of the committee of jurisdiction of the D.C. Council, the council member, Wilhelmina Rolark, to come forward and present her testimony and prepare for questions which the committee may have for her.

It's a real pleasure, Ms. Rolark, to have you. We appreciate the fine job that you are doing as Chair of the committee on the judiciary of the council, and the fine representation you give to a very important segment of our population in the District of Columbia.

TESTIMONY OF HON. WILHELMINA ROLARK, COUNCIL OF THE DISTRICT OF COLUMBIA

Ms. ROLARK. Good morning. Thank you very much for allowing me to testify. Appearing with me this morning, on my right is attorney Kemi Morten, the staff director of the committee on the judiciary; on the left, Attorney Mike Battle who is a budget analyst for the committee on the judiciary.

Good morning, Congressman Fauntroy and staff members of the District Committee. I am council member, Wilhelmina Rolark, chairperson of the District of Columbia City Council's Committee on the Judiciary. As Chair of that committee, I do have operational and fiscal oversight of the District of Columbia Fire Department.

I appreciate this opportunity that you've given me to appear this morning and give my comments on the situation with which we are faced. Over the past year, as you well know, there has been a great deal of criticism concerning the delivery of ambulance services by the D.C. Fire Department.

In the spring of 1986, and it's been alluded to here by Mr. Downs in his testimony and questions have arisen on it, the Mayor's advisory committee on emergency health service established a task force to examine the delivery of emergency ambulance service in

the District of Columbia. This task force issued a report which was critical of the department, indicating that District ambulance crews were poorly trained, used substandard equipment and failed to keep adequate medical records.

Therefore, in September and, particularly, on September 17, 1986, the committee on the judiciary held an oversight hearing to consider this report. At that time it was learned that the report of the task force was preliminary only and had not yet been voted on by the entire task force. Additionally, the fire department, while agreeing that there were some deficiencies in the division, indicated that many of the areas of concern named by that task force did not exist in the division, and that the department had already begun corrective action on many of the other deficiencies that they listed.

We all know that since September of 1986, that is, since that report and since the first oversight hearing that was held by the committee on the judiciary of the D.C. Council, there have been allegations that several persons may have lost their lives or sustained serious injuries as a result of slow response time by the emergency ambulance division or mistakes by dispatchers in the communications division.

Others have charged that the city council and the Mayor have been indifferent and inactive on this issue. I don't think anything could be further from the truth. The council—Mr. Downs has testified rather eloquently on the response of the executive. The council has not been silent on this issue. On the contrary, and in fact, completely to the contrary, the council under my leadership, which I do Chair that committee that does address this problem, has been steadfast in its vigorous and stringent monitoring of both 911 and the emergency ambulance division.

During the annual budget processes, Chairman Fauntroy, the fire and police departments have consistently been questioned as to their staffing levels, training, equipment and availability of services within all of their divisions. The council has provided additional funds and authorization in excess of these departments' budget requests to provide additional staffing and equipment to ensure adequate resources not only for the emergency ambulance division but for the entire fire department.

In addition, in 1985 the council provided an additional $1.7 million to hire new personnel to fully staff the ambulance division, to increase the numbers of ambulances in service, and to enhance personnel training.

In 1986 the council created new emergency positions and provided $81,000 for an additional life support—an advanced life support unit. In 1987 we provided additional emergency ambulance positions and provided $350,000 to permit 24-hour manning of both rescue squad No. 3 and the hazardous material unit.

In March, as part of the fiscal year 1988 budget recommendations, the council provided an additional $173,000 to the department to double the size of its paramedic training classes, and directed that the department convene the additional classes simultaneously with the first, even if this meant hiring a second contractor.

During the fiscal year 1987 supplemental budget process, just recently concluded, the committee approved significant increases in the budget of the department to improve services in this area. The majority of the nonpersonal services increase of $682,000 were directly related to upgrading ambulance services in the District. Additionally, the entire $1.5 million capital pay-as-you-go request was related to upgrading ambulance services.

Additionally, the committee directed the department to study the feasibility of placing the three new ambulance vehicles to be purchased through supplemental capital authority on line rather than using the vehicles as replacement units for ambulances in need of services.

It is clear that the council has consistently provided sufficient funding for the fire department over the years to fully staff and equip the ambulance division, and that whatever problems may exist in the department are not due to disinterest or inactivity on the part of the council, as has been alleged.

On April 3, 1987, the committee on the judiciary held its second oversight hearing on the emergency ambulance division in 7 months to investigate the latest allegations concerning the division. At that time, the committee found that overall the fire department, under the leadership of Chief Theodore Coleman, is doing a fine job of providing fire protection and emergency medical services to the citizens of the District of Columbia.

Several of my colleagues on the committee and on the council expressed satisfaction at that time with the job being performed by the men and women of the fire department, but agreed with me that further improvement is urgently needed in certain areas. I firmly believe that the priority dispatch system, as presently practiced, should be eliminated. The system, in my opinion and in the opinion of members of the committee and in part of our recommendations as a result of that hearing, delays the dispatching of ambulance units in emergency situations.

Persons in need of an emergency ambulance are likely to be excitable and involved in unpredictable situations. Requiring them to answer questions on the medical status of the injured party only adds more stress to an already stressful situation. Additionally, if they are medically untrained, they may give inaccurate information, causing an incorrect priority to be given to the call, resulting sometimes in tragedy.

I believe it is preferable, and it was part of our recommendations which were given to the entire council and to members of the involved department, to dispatch an ambulance immediately after receiving a call for assistance, and determine the priority on the scene, as is the practice in some of our neighboring jurisdictions, particularly in Baltimore which does not have an official prioritizing system, rather than attempting to pick and choose among persons in need.

Elimination of this system would require the District to purchase additional ambulances to ensure that all calls could be answered more quickly. The District currently has nine ambulance units on reserve status. While these are older units, they could be used to supplement our current fleet until new ambulances could be ordered.

Additionally, as I stated previously, the department could place on line the three new ambulances which will be purchased with supplemental capital authority rather than placing them in reserve. I understand that the fire department is currently studying all of these recommendations.

The committee also found that sensitivity and stress training is sorely needed for fire department personnel in frontline positions that directly interface with the public. Specifically, communications workers, ambulance drivers and emergency medical technicians, because discourteous, rude and unprofessional attitudes often caused by overworked employees should not be tolerated, and cannot be tolerated. To its credit, and I must say, to its great credit, the department immediately addressed this problem, and has already announced plans, and they have elucidated them to you this morning, to provide such training.

Most recently the department has addressed other committee concerns through its fiscal year 1987 supplemental budget. The fire department has requested an increase of over $2 million in its budget, all of which was earmarked for the emergency ambulance service division.

Included are plans to upgrade the entire communications system of the fire department with the purchase of new computer equipment, and the use of an 800 Mgh radio system that has been addressed here, I think, by both Mr. Downs and Mr. Yeldell, and the decision to increase stocks in basic equipment and supplies.

During our oversight hearing considerable concern was expressed that ambulances were not being replaced quickly enough. Ambulance calls increased dramatically in fiscal year 1986 to 125,000 runs, which is a large number, shortening the useful life of each ambulance. The council has been assured that new ambulances will be purchased through supplemental authority.

During my inspection of the fire department's communications division, which occurred on the afternoon of April 2, 1987, 10 ambulance calls and 9 fire calls came in during just a brief period of 20 minutes. During that time, of the 21 active ambulances in our fleet, at no time were more than 3 ambulances in their own stations. The vast majority, therefore, were on the street responding to calls.

I am sensitive to the fact, Chairman Fauntroy, that the magnitude of the work expected of emergency service personnel is very staggering. Nevertheless, I am committed to ensuring that this great challenge is met by us.

Chief Coleman announced during the oversight hearing that the division would be up to its full complement of 302 members before the end of April. He also indicated he would be acting swiftly to fill 15 vacancies in the communications division. I am confident that these changes will enhance the department's ability to respond to emergencies in our city.

Finally, as a long-term goal, I am currently—as Chair of this committee, I am currently considering the impact of upgrading the entire ambulance fleet to advanced life support units. This would require additional training for emergency ambulance technicians to upgrade them to paramedic status. The upgrading of our current 15 basic ambulance units with additional supplies and telemetry

equipment and, above all, this will require a substantial—and I think I'm talking with the right people now—fiscal investment. I trust that this Congress will support the necessary budget increase, should this approval be found to be viable by all parties concerned, that is, the executive and the council.

The citizens of the District of Columbia deserve the best possible ambulance service that can be provided, and in my capacity as Chair of the judiciary committee with oversight of this department, I remain committed to that.

I cannot conclude without addressing the District's residency requirement. One of the major problems has been the shortage of fully trained paramedics to man all of the advanced life support units. Because of this shortage, some have called for an end to the residency requirement as a solution for filling emergency ambulance personnel positions. I am opposed, and I must say, unalterably opposed, to exempting emergency ambulance division personnel from the residency requirement; and I want the record to reflect that. I'm opposed to this, because I do not believe that such an action will solve the shortage in paramedics.

For example, the city of Baltimore, which has no residency requirement—but the Baltimore ambulance service is encountering paramedic staffing problems very similar to our own, and personnel shortages will and do occur.

However, in Baltimore two fully trained paramedics are assigned to each ambulance. In the District we assign one paramedic and one intermediate paramedic to each advanced unit. There must be one fully trained paramedic on each advanced life support unit. In Baltimore, if there is a personnel shortage, the unit can be manned by one paramedic and EMT certified firefighter. In the District, if the full paramedic is absent, the unit cannot be manned as the advanced life support unit, but can be manned as a basic unit. So there could be some management things considered that would address this problem, but certainly not the elimination of the residency requirement or an exemption. They will not solve it, in my opinion; and I am opposed to that.

A few years ago the Baltimore fire department began providing emergency medical technician certification for all of its fire academy graduates. I had a staff member to go over and study the Baltimore situation for the committee. Firefighters are required to maintain this certification as a condition of employment. As a result, a large portion of their firefighters are EMT certified.

I understand that the District is studying or plans to adopt this policy and, in my view, this will provide a better alternative to the personnel shortage problem than abolishing the residency requirement.

Regarding the District's 911 system, the council has held a number of oversight hearings on the operations of this system. It is a new system and, as such, time will be required to work out many of the deficiencies. In that regard, I join in the remarks of the executive branch. But I would like to point out, Chairman Fauntroy, that we found, during our hearings, that a number of nonemergency calls are made by the public; and, surely, with such a crisis as we are addressing today, criticisms of the department coming

from the public, we cannot overlook the role of the public in helping to solve this.

So I feel that the public information or the public education program has got to be addressed both by yourselves and by us and by the involved media. We said this at the oversight hearings, and we still say it. A lot of times big problems are addressed with public information, you know; that is, the public itself should be exhorted through the electronic media and through the press media and through every area that we do have, not to make those nonemergency calls on 911. Also, the role of the public insofar as the delivery of service and response time of the ambulance system cannot be overlooked.

I know you must have seen in your capacity as a citizen of the District of Columbia, many times when an ambulance simply can't get through the traffic. We are seriously considering legislation to increase the fine, which now is set at only $50, to perhaps as high as $300 to implement public cooperation in this regard.

Also, we have considered at some of our hearings the police providing special escorts during very peak times, you know, when you almost have what you call a gridlock situation that erupts in the District of Columbia, and when ambulances simply cannot get through.

These are situations that don't reflect the management of the fire department or anything we are doing or not doing at all. They involve the public. The public must cooperate in the solution of the crisis, because the public is part of the problem; and all of us, including the public, want to have it resolved.

I have told this committee that the council will continue to closely monitor the city's implementation of the stated goals and proposals.

In ending, let me say that I am impressed with the executive's commitment to improve the District's delivery of emergency services. In grappling with this issue, I have developed a strong working relationship with the chiefs of the respective departments.

With the support of this Congress, under your leadership and those others who are involved, I am confident that the District will resolve this crisis and further ensure the safety of residents and visitors to the Nation's Capital.

If necessary, I'll be glad to respond to any questions you and the other members of this distinguished panel may have.

[The prepared statement of Ms. Rolark follows:]

TESTIMONY OF

COUNCILMEMBER WILHELMINA J. ROLARK, CHAIRPERSON

COMMITTEE ON THE JUDICIARY

COUNCIL OF THE DISTRICT OF COLUMBIA

BEFORE THE

SUBCOMMITTEE ON FISCAL AFFAIRS AND HEALTH

COMMITTEE ON THE DISTRICT OF COLUMBIA

AUGUST 5, 1987

GOOD MORNING. I AM COUNCILMEMBER WILHELMINA J. ROLARK, CHAIRPERSON OF THE DISTRICT OF COLUMBIA CITY COUNCIL'S COMMITTEE ON THE JUDICIARY. AS CHAIR, I HAVE OPERATIONAL AND FISCAL OVERSIGHT OF THE DISTRICT OF COLUMBIA FIRE DEPARTMENT.

OVER THE PAST YEAR, THERE HAS BEEN A GREAT DEAL OF CRITICISM CONCERNING THE DELIVERY OF AMBULANCE SERVICES BY THE D.C. FIRE DEPARTMENT.

IN THE SPRING OF 1986, THE MAYOR'S ADVISORY COMMITTEE ON EMERGENCY HEALTH SERVICE ESTABLISHED A TASK FORCE TO EXAMINE THE DELIVERY OF EMERGENCY AMBULANCE SERVICE IN THE DISTRICT OF COLUMBIA. THIS TASK FORCE ISSUED A REPORT CRITICAL OF THE DEPARTMENT, INDICATING THAT DISTRICT AMBULANCE CREWS WERE POORLY TRAINED, USED SUBSTANDARD EQUIPMENT AND FAILED TO KEEP ADEQUATE MEDICAL RECORDS.

ON SEPTEMBER 17, 1986, THE COMMITTEE ON THE JUDICIARY HELD AN OVERSIGHT HEARING TO CONSIDER THE REPORT OF THE TASK FORCE. AT THE TIME IT WAS LEARNED THAT THE REPORT OF THE TASK FORCE WAS PRELIMINARY ONLY AND HAD NOT YET BEEN VOTED ON BY THE TASK FORCE. ADDITIONALLY, THE FIRE DEPARTMENT, WHILE AGREEING THAT THERE ARE SOME DEFICIENCIES IN THE DIVISION, INDICATED THAT MANY OF THE AREAS OF CONCERN NAMED BY THE TASK FORCE DID NOT EXIST IN THE DIVISION AND THAT THE DEPARTMENT HAD ALREADY TAKEN CORRECTIVE ACTION ON MANY OF THE OTHER DEFICIENCIES LISTED BY THE TASK FORCE.

WE ALL KNOW THAT SINCE SEPTEMBER OF 1986, THERE HAVE BEEN ALLEGATIONS THAT SEVERAL PERSONS MAY HAVE LOST THEIR LIVES OR SUSTAINED SERIOUS INJURY AS A RESULT OF SLOW RESPONSE TIME BY THE EMERGENCY AMBULANCE DIVISION OR MISTAKES BY DISPATCHERS IN THE COMMUNICATIONS DIVISION. OTHERS HAVE CHARGED THAT THE CITY COUNCIL AND THE MAYOR HAVE BEEN INDIFFERENT AND INACTIVE ON THIS ISSUE. NOTHING CAN BE FURTHER FROM THE TRUTH. THE COUNCIL HAS NOT BEEN SILENT ON THIS ISSUE. ON THE CONTRARY, UNDER MY LEADERSHIP THE COUNCIL HAS BEEN

STEADFAST IN ITS VIGOROUS AND STRINGENT MONITORING OF BOTH 911 AND THE EMERGENCY AMBULANCE DIVISION. DURING THE ANNUAL BUDGET PROCESSES THE FIRE AND POLICE DEPARTMENTS HAVE CONSISTENTLY BEEN QUESTIONED AS TO STAFFING LEVELS, TRAINING, EQUIPMENT AND AVAILABILITY OF SERVICES WITHIN ALL OF ITS DIVISIONS. THE COUNCIL HAS PROVIDED ADDITIONAL FUNDS AND AUTHORIZATION IN EXCESS OF THE DEPARTMENTS' BUDGET REQUEST TO PROVIDE ADDITIONAL STAFFING AND EQUIPMENT TO ENSURE ADEQUATE RESOURCES NOT ONLY FOR THE EMERGENCY AMBULANCE DIVISION, BUT FOR THE ENTIRE DEPARTMENT.

IN 1985, THE COUNCIL PROVIDED AN ADDITIONAL 1.7 MILLION DOLLARS TO HIRE NEW PERSONNEL TO FULLY STAFF THE AMBULANCE DIVISION, INCREASE THE NUMBERS OF AMBULANCES IN SERVICE, AND ENHANCE PERSONNEL TRAINING.

IN 1986 THE COUNCIL CREATED NEW EMERGENCY POSITIONS AND PROVIDED $81,000 FOR AN ADDITIONAL ADVANCED LIFE SUPPORT UNIT. IN 1987, WE PROVIDED ADDITIONAL EMERGENCY AMBULANCE POSITIONS AND PROVIDED $350,000 TO PERMIT 24 HOUR MANNING OF BOTH RESCUE SQUAD #3 AND THE HAZARDOUS MATERIAL UNIT.

IN MARCH AS PART OF ITS FY'88 BUDGET RECOMMENDATIONS, THE COUNCIL PROVIDED AN ADDITIONAL $173,000 TO THE DEPARTMENT TO DOUBLE THE SIZE OF ITS PARAMEDIC TRAINING CLASSES AND DIRECTED THE DEPARTMENT TO CONVENE THE ADDITIONAL CLASSES SIMULTANEOUSLY WITH THE FIRST, EVEN IF THIS MEANT HIRING A SECOND CONTRACTOR.

DURING THE FY 87 SUPPLEMENTAL BUDGET PROCESS, THE COMMITTEE APPROVED SIGNIFICANT INCREASES IN THE BUDGET OF THE DEPARTMENT TO IMPROVE SERVICE IN THIS AREA. THE MAJORITY OF THE NONPERSONAL SERVICES INCREASE OF $682,000 WERE DIRECTLY RELATED TO UPGRADING AMBULANCE SERVICES IN THE DISTRICT. ADDITIONALLY, THE ENTIRE 1.5 MILLION CAPITAL PAY-AS-YOU-GO REQUEST WAS RELATED TO UPGRADING AMBULANCE SERVICES. ADDITIONALLY, THE COMMITTEE DIRECTED THE DEPARTMENT TO STUDY THE FEASIBILITY OF PLACING THE 3 NEW AMBULANCE VEHICLES TO

BE PURCHASED THROUGH SUPPLEMENTAL CAPITAL AUTHORITY ON LINE RATHER THAN USING THE VEHICLES AS REPLACEMENT UNITS FOR AMBULANCES IN NEED OF SERVICE.

IT IS CLEAR THAT THE COUNCIL HAS CONSISTENTLY PROVIDED SUFFICIENT FUNDING FOR THE FIRE DEPARTMENT OVER THE YEARS TO FULLY STAFF AND EQUIP THE AMBULANCE DIVISION, AND THAT WHATEVER PROBLEMS MAY EXIST IN THE DEPARTMENT ARE NOT DUE TO DISINTEREST OR INACTIVITY ON THE PART OF THE COUNCIL.

ON APRIL 3, 1987, THE COMMITTEE ON THE JUDICIARY HELD ITS SECOND OVERSIGHT HEARING ON THE EMERGENCY AMBULANCE DIVISION IN 7 MONTHS TO INVESTIGATE THE LATEST ALLEGATIONS CONCERNING THE DIVISION.

AT THAT TIME, THE COMMITTEE FOUND THAT OVERALL, THE FIRE DEPARTMENT, UNDER THE LEADERSHIP OF CHIEF THEODORE COLEMAN IS DOING A FINE JOB OF PROVIDING FIRE PROTECTION AND EMERGENCY MEDICAL SERVICES TO THE CITIZENS OF THE DISTRICT OF COLUMBIA. SEVERAL OF MY COLLEAGUES EXPRESSED SATISFACTION WITH THE JOB PERFORMED BY THE MEN AND WOMEN OF THE FIRE DEPARTMENT BUT AGREED WITH ME THAT FURTHER IMPROVEMENT IS URGENTLY NEEDED IN CERTAIN AREAS.

I FIRMLY BELIEVE THAT THE PRIORITY DISPATCH SYSTEM SHOULD BE ELIMINATED. THE SYSTEM UNNECESSARILY DELAYS THE DISPATCHING OF AMBULANCE UNITS IN EMERGENCY SITUATIONS.

PERSONS IN NEED OF AN EMERGENCY AMBULANCE ARE LIKELY TO BE EXCITABLE AND INVOLVED IN AN UNPREDICTABLE SITUATION. REQUIRING THEM TO ANSWER QUESTIONS ON THE MEDICAL STATUS OF THE INJURED PARTY ONLY ADDS MORE STRESS TO AN ALREADY STRESSFUL SITUATION. ADDITIONALLY, IF THEY ARE MEDICALLY UNTRAINED, THEY MAY GIVE INACCURATE INFORMATION, CAUSING AN INCORRECT PRIORITY TO BE GIVEN TO THE CALL, RESULTING IN TRAGEDY. I BELIEVE IT IS PREFERABLE TO DISPATCH AN AMBULANCE IMMEDIATELY AFTER RECEIVING A CALL FOR ASSISTANCE, AND DETERMINE THE PRIORITY ON THE SCENE AS IS THE PRACTICE IN NEIGHBORING JURISDICTIONS, RATHER THAN ATTEMPTING TO PICK AND CHOOSE AMONG PERSONS IN NEED.

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ELIMINATION OF THE PRIORITY DISPATCH SYSTEM WOULD REQUIRE THE DISTRICT TO PURCHASE ADDITIONAL AMBULANCES TO ENSURE THAT ALL CALLS COULD BE ANSWERED QUICKLY. THE DISTRICT CURRENTLY HAS NINE AMBULANCE UNITS ON RESERVE STATUS. WHILE THESE ARE OLDER UNITS, THEY COULD BE USED TO SUPPLEMENT OUR CURRENT FLEET UNTIL NEW AMBULANCES COULD BE ORDERED. ADDITIONALLY, AS I STATED PREVIOUSLY, THE DEPARTMENT SHOULD PLACE ON LINE THE 3 NEW AMBULANCES WHICH WILL BE PURCHASED WITH SUPPLEMENTAL CAPITAL AUTHORITY RATHER THAN PLACING THEM IN RESERVE. I UNDERSTAND THAT THE FIRE DEPARTMENT IS CURRENTLY STUDYING THIS PROPOSAL.

THE COMMITTEE ALSO FOUND THAT SENSITIVITY AND STRESS TRAINING IS SORELY NEEDED FOR FIRE DEPARTMENT PERSONNEL IN FRONTLINE POSITIONS THAT DIRECTLY INTERFACE WITH THE PUBLIC. SPECIFICALLY, COMMUNICATIONS WORKERS, AMBULANCE DRIVERS AND EMERGENCY MEDICAL TECHNICIANS. DISCOURTEOUS, RUDE AND UNPROFESSIONAL ATTITUDES, OFTEN CAUSED BY OVERWORKED EMPLOYEES, SHOULD NOT BE TOLERATED. TO ITS CREDIT, THE DEPARTMENT IMMEDIATELY ADDRESSED THIS PROBLEM AND HAS ALREADY ANNOUNCED PLANS TO PROVIDE SUCH TRAINING.

MOST RECENTLY, THE DEPARTMENT HAS ADDRESSED OTHER COMMITTEE CONCERNS THROUGH ITS FY 87 SUPPLEMENTAL BUDGET. THE FIRE DEPARTMENT REQUESTED AN INCREASE OF OVER $2,000,000 IN ITS BUDGET, ALL OF WHICH WAS EARMARKED FOR THE EMERGENCY AMBULANCE SERVICE DIVISION.

INCLUDED ARE PLANS TO UPGRADE THE ENTIRE COMMUNICATIONS SYSTEM OF THE FIRE DEPARTMENT WITH THE PURCHASE OF NEW COMPUTERS, EQUIPMENT AND THE USE OF AN 800 MEGAHERTZ RADIO SYSTEM, AND THE DECISION TO INCREASE STOCKS IN BASIC EQUIPMENT AND SUPPLIES.

DURING THE OVERSIGHT HEARING CONSIDERABLE CONCERN WAS EXPRESSED THAT AMBULANCES WERE NOT BEING REPLACED QUICKLY ENOUGH. AMBULANCE CALLS INCREASED DRAMATICALLY IN FY 1986 TO 125,000 RUNS, SHORTENING THE USEFUL LIFE OF EACH

AMBULANCE. THE COUNCIL HAS BEEN ASSURED THAT NEW AMBULANCES WILL BE PURCHASED THROUGH SUPPLEMENTAL AUTHORITY.

DURING MY INSPECTION OF THE FIRE DEPARTMENT'S COMMUNICATIONS DIVISION ON THE AFTERNOON OF APRIL 2, 1987, TEN AMBULANCE CALLS AND NINE FIRE CALLS CAME IN DURING A 20 MINUTE PERIOD. DURING THAT SAME TIME, OF THE 21 ACTIVE AMBULANCES IN OUR FLEET, AT NO TIME WERE MORE THAN THREE AMBULANCES IN THEIR HOME STATIONS. THE VAST MAJORITY WERE ON THE STREET RESPONDING TO CALLS. I AM SENSITIVE TO THE FACT THAT THE MAGNITUDE OF THE WORK EXPECTED OF EMERGENCY SERVICE PERSONNEL IS STAGGERING. NEVERTHELESS, I AM COMMITTED TO ENSURING THAT THIS GREAT CHALLENGE IS MET. CHIEF COLEMAN ANNOUNCED DURING THE OVERSIGHT HEARING THAT THE DIVISION WOULD BE UP TO ITS FULL COMPLEMENT OF 302 MEMBERS BEFORE THE END OF APRIL. HE ALSO INDICATED THAT HE WOULD BE ACTING SWIFTLY TO FILL 15 VACANCIES IN THE COMMUNICATIONS DIVISION. I AM CONFIDENT THAT THESE CHANGES WILL ENHANCE THE DEPARTMENT'S ABILITY TO RESPOND TO EMERGENCIES IN OUR CITY.

FINALLY, AS A LONG TERM GOAL, I AM CURRENTLY CONSIDERING THE IMPACT OF UPGRADING THE ENTIRE AMBULANCE FLEET TO ADVANCED LIFE SUPPORT UNITS. THIS WOULD REQUIRE ADDITIONAL TRAINING FOR EMERGENCY AMBULANCE TECHNICIANS TO UPGRADE THEM TO PARAMEDIC STATUS, THE UPGRADING OF OUR CURRENT 15 BASIC AMBULANCE UNITS WITH ADDITIONAL SUPPLIES AND TELEMETRY EQUIPMENT AND ABOVE ALL, THIS WILL REQUIRE A SUBSTANTIAL FISCAL INVESTMENT. I TRUST THAT THIS CONGRESS WILL SUPPORT THE NECESSARY BUDGET INCREASES SHOULD THIS APPROVAL BE FOUND TO BE VIABLE.

THE CITIZENS OF THE DISTRICT OF COLUMBIA DESERVE THE BEST POSSIBLE AMBULANCE SERVICE THAT CAN BE PROVIDED, AND IN MY CAPACITY AS CHAIR OF THE JUDICIARY COMMITTEE WITH OVERSIGHT OF THE FIRE DEPARTMENT, I REMAIN COMMITTED TO ENSURING THAT SUCH SERVICE IS PROVIDED.

Z

I CANNOT CONCLUDE WITHOUT ADDRESSING THE DISTRICT'S RESIDENCY REQUIREMENT. ONE OF THE MAJOR PROBLEMS HAS BEEN THE SHORTAGE OF FULLY TRAINED PARAMEDICS TO MAN ALL OF THE ADVANCED LIFE SUPPORT UNITS. BECAUSE OF THIS SHORTAGE, SOME HAVE CALLED FOR AN END TO THE RESIDENCY REQUIREMENT FOR EMERGENCY AMBULANCE PERSONNEL. I AM OPPOSED TO EXEMPTING EMERGENCY AMBULANCE DIVISION PERSONNEL FROM THE RESIDENCY REQUIREMENT. I DO NOT BELIEVE THAT SUCH AN ACTION WILL SOLVE THE SHORTAGE IN PARAMEDICS. FOR EXAMPLE, THE CITY OF BALTIMORE HAS NO RESIDENCY REQUIREMENT BUT THE BALTIMORE AMBULANCE SERVICE IS ENCOUNTERING PARAMEDIC STAFFING PROBLEMS SIMILAR TO OUR OWN AND PERSONNEL SHORTAGES DO OCCUR. HOWEVER, IN BALTIMORE, TWO FULLY TRAINED PARAMEDICS ARE ASSIGNED TO EACH AMBULANCE. IN THE DISTRICT WE ASSIGN 1 PARAMEDIC AND 1 INTERMEDIATE PARAMEDIC TO EACH ADVANCED UNIT. THERE MUST BE ONE FULLY TRAINED PARAMEDIC ON EACH ADVANCED LIFE SUPPORT UNIT. IN BALTIMORE IF THERE IS A PERSONNEL SHORTAGE, THE UNIT CAN BE MANNED BY ONE PARAMEDIC AND EMT CERTIFIED FIREFIGHTER. IN THE DISTRICT IF THE FULL PARAMEDIC IS ABSENT THE UNIT CAN NOT BE MANNED AS THE ADVANCED LIFE SUPPORT UNIT, BUT CAN BE MANNED AS A BASIC UNIT.

A FEW YEARS AGO, THE BALTIMORE FIRE DEPARTMENT BEGAN PROVIDING EMERGENCY MEDICAL TECHNICIAN CERTIFICATION FOR ALL FIRE ACADEMY GRADUATES. FIREFIGHTERS ARE REQUIRED TO MAINTAIN THIS CERTIFICATION AS A CONDITION OF EMPLOYMENT. AS A RESULT, A LARGE PORTION OF THEIR FIREFIGHTERS ARE EMT CERTIFIED. I UNDERSTAND THAT THE DISTRICT PLANS TO ADOPT THIS POLICY AND IN MY VIEW THIS WILL PROVIDE A BETTER ALTERNATIVE TO THE PERSONNEL SHORTAGE PROBLEM THAN ABOLISHING THE RESIDENCY REQUIREMENT.

REGARDING THE DISTRICT'S 911 SYSTEM THE COUNCIL HAS HELD A NUMBER OF OVERSIGHT HEARINGS ON THE OPERATIONS OF THIS SYSTEM. IT IS A NEW SYSTEM AND AS SUCH TIME WILL BE REQUIRED TO WORK OUT MANY OF THE DEFICIENCIES. IN THAT

REGARD I JOIN IN THE REMARKS OF THE EXECUTIVE BRANCH. I ASSURE THIS COMMITTEE THAT THE COUNCIL WILL CONTINUE TO CLOSELY MONITOR THE CITY'S IMPLEMENTATION OF ITS STATED GOALS AND PROPOSALS.

IN ENDING, LET ME SAY THAT I AM IMPRESSED WITH THE EXECUTIVE'S COMMITMENT TO IMPROVE THE DISTRICT'S DELIVERY OF EMERGENCY SERVICES. IN GRAPPLING WITH THIS ISSUE I HAVE DEVELOPED A STRONG WORKING RELATIONSHIP WITH THE CHIEFS OF THE RESPECTIVE DEPARTMENTS. WITH THE SUPPORT OF CONGRESS, I AM CONFIDENT THAT THE DISTRICT WILL RESOLVE THIS CRISIS AND FURTHER ENSURE THE SAFETY OF RESIDENTS OF AND VISITORS TO THE NATION'S CAPITAL.

Mr. FAUNTROY. Thank you so very much, Councilmember Rolark. Your testimony has been certainly thorough, instructive and encouraging to this member and, I'm sure, to many Members of the Congress as they would have an opportunity to read it, for the reason that it assures us that the legislative oversight functions which the Congress delegated to duly elected citizens from the District of Columbia on the D.C. Council are being discharged with great efficiency and care and, on this particular problem, with exhaustive effort. For that, I want to express my appreciation to you as a locally elected official and as Chair of the committee of jurisdiction here, the committee on the judiciary for, obviously, a very vigorous pursuit of your responsibility in this area.

Ms. ROLARK. Thank you very much.

Mr. FAUNTROY. Let me ask, are you satisfied with the executive branch cooperation with the council in the effort to overcome the problems that you've been looking at here; and is there a partnership at work?

Ms. ROLARK. There is a partnership at work, and I am completely satisfied with it. As with any partnership, you know, some people say a partnership is—not to use profanity, of course, Mr. Chairman, but I've heard it among lawyers—the damndest ship you ever sail, but that's not true of this partnership. This partnership is a good working relationship. When we encounter difficulties, we work them out. We're working them out now, and we do want the cooperation of the public and, of course, yourself.

Mr. FAUNTROY. Yes. You made references to the role of the public, and some have suggested that a comprehensive emergency response law might help in resolving the District's problems. Have you given any thought to drafting or introducing such legislation?

Ms. ROLARK. I will, of course, give complete thought to any legislation that's suggested, and I'm just talking with the staff director here. I think we are beginning a study of it. They are working on it now and will be coming to me with their recommendations.

Mr. FAUNTROY. What is your view of the suggestion that the emergency ambulance service be removed from the fire department?

Ms. ROLARK. I agree with Mr. Downs in that respect, and I do not have all of the information that he gave you about comparable with jurisdiction and comparable placement of the service, but it's just my commonsense and view of it that it is properly placed within the fire department; because of the speed with which these calls can be addressed. The fire department is the department that people look to to come quickly in emergency situations. I feel, with the emergency ambulance service, it should be in a department that's fully equipped to give the speed the public wants, because when you're sick and when you're in that type of health jeopardy, that's what you want is speed to address your problem. It's properly placed, in my opinion.

Mr. FAUNTROY. Let me say that I did take dire note of your suggestion that additional funds may be necessary to assure the very best in terms of emergency response services, and I will pass that on. But how do you think the District's system compares with other jurisdictions presently?

Ms. ROLARK. Recently, I was in New York at a convention, and the headlines there—I felt like I was here, because the headlines there were very critical, blaring headlines about the deficiencies in the delivery of emergency ambulance service in New York. I was astounded to find that the response time there was almost 8 minutes longer than our response time; and that was the critical basis on which these news articles were being written and on which the reviews of the inadequacies as they saw it in the delivery of emergency ambulance service were being addressed.

So in New York, I was there for over a week, that was the issue, the delivery of emergency ambulance service, with which the public was not satisfied. So I feel that, comparably speaking, that we are ahead; because New York is a big, big city, you know, and people often look to New York, for example, because of the money that's there and the power and all the rest that's there. But when I see that our response time is so much better than their response time—and that, as I said in the beginning, is the real bottom line, how fast can you get there to deliver that service. Response time is the key.

I feel that comparably speaking—and, of course, very recently—and it's not being overly critical of our neighbors, but we always look at our neighbors, because we are Washington metropolitan area, and so we are close. We may not be close, as you say, in power. You can't vote and so forth, like that; but we are close in what happens to us, because sometimes what happens here spills over in what happens there, and the problems that they are having in our neighbor of Fairfax with the 911 make me know that what we are doing here with the 911 may on target be favorable—be very, very—be, in my opinion, superior.

We've worked very hard, and we are trying to improve it. But there, as here, I am sure the role of the public has also got to be addressed; because when the public makes nonemergency calls—and that, too, was part of the problem in New York, the fact that even though response time was slow, a lot of it was being—was done in answering calls that were not necessary for emergency ambulance service, some serious perhaps but not emergency ambulance service, and what it did. It diffused their ability to respond properly. So the role of the public has to be addressed here, since it is a publicly inspired thing. The public is dissatisfied. So the public has also got to look at itself.

Mr. FAUNTROY. Certainly. Now you will recall, in my opening statement I referenced the fact that this is a national problem, and one of the reasons I think Members of the Congress are appreciative of the initiative that Congressman Parris has taken in this regard is that they recognize it is a national problem and that we ought to, as Members of the Congress, take a good look at the jurisdictions closest to Capitol Hill with a view to perhaps being able to suggest to our various jurisdictions back home how they can follow the example that Mr. Downs has promised, namely, that we will have the best in the region as a result of the kind of work that both you and the executive branch are pursuing at this time.

I am going to yield to Mr. Parris for questions and, as I do, let me just bring him up to date. I have asked Mr. Downs and his panel to remain so that you might continue your questioning of

them, but at this time you may, if you will, question our distinguished Chair of the judiciary committee in the D.C. Council, Councilwoman Wilhelmina Rolark.

Mr. PARRIS. I thank you, Mr. Chairman. Again, Ms. Rolark, I apologize for not being here during the presentation of your testimony. We have just received a copy of your statement, and I've had no opportunity to review it; and I want to just make one observation. I have no questions as such, but I want to make one observation.

I notice on page 4 that you oppose the priority dispatch service, and I congratulate you on your judgment and your position in that regard. You make the point extremely well that to require persons who are in stressful and unpredictable situations to answer questions on the medical status of an injured party adds additional stress to an already enormously stressful situation, and to make people pick and choose on the telephone as a result of laymen's categorizations of the degree of the severity of the problem, I think, is a wrongheaded solution to the problem, particularly when those persons are not medically trained.

So let me just make one observation in regard to a statement that you made, and I'll relinquish the time back to the chairman.

It's not just the response time, although that is important, Ms. Rolark. Equally critical to this problem is what happens after you respond, and the adequacy of treatment and the training of the personnel and all the rest of it then becomes critically important.

So as concerned as we all are about response time, that's just a portion of the problem.

I thank you, Mr. Chairman.

Mr. FAUNTROY. I thank the gentleman. I thank Chairperson Rolark for her testimony.

Ms. ROLARK. Thank you very much.

Mr. FAUNTROY. I'm going to ask Mr. Downs and Mr. Yeldell and the chief and Dr. Miller to return briefly to the witness table, and I want to afford Mr. Parris the opportunity to raise any additional questions that he may wish to raise of the executive branch on this whole question.

Mr. PARRIS. I thank you, Mr. Chairman. I will try to be brief in my questioning.

According to the EMS statistics that we've received and reviewed, approximately 40 percent of the ambulance calls that are dealt with in the District turn out to be no more than what I call taxi rides, nonmedical emergencies of one kind or another. I would add, this is not perhaps reliable information in terms of a random sample, but in the 20 hours or so that the members of my staff spent with the D.C. Ambulance Medical Unit, 74 percent of the calls that they experienced in that limited time frame were classified as nonmedical emergencies, where some citizen who for one reason or another wants to get from this point to that point, and a nice, cheap, convenient way to do that is ride an ambulance. So they call 911. Now I'm sure, Mr. Downs, that you would agree that what we would be well advised to expend our efforts in doing is to try to stop those people from calling 911. I think Ms. Rolark alluded to that a moment ago—unless there is a true emergency, and

educating the citizens of the District and those who use that service as to what a true emergency is.

Now she covered some of the efforts to attempt to do that, and I congratulate the city in that regard. My question for the ladies and gentlemen of the panel is why won't the city give the emergency medical personnel the right to refuse transport? There is no judgment, I'm told, latitude, if that's the right word, given to those persons to make a judgment. Why not?

Mr. Downs. That's not exactly the fact either in practice or in law. There is some concern about—as I understand it, in the field about making the determination that someone is not in need of transport. I think everyone has a fear of making the wrong judgment.

There was a piece in the Post, for instance, of the individual who called and said I have a headache. Then the dispatcher said that's probably not an appropriate thing, and maybe you should think about just taking an aspirin or something or calling your physician. The individual had a cerebral hemorrhage and dropped dead. He didn't have a headache.

Making those kinds of determinations on the street are very difficult for personnel, about making a decision that someone does not need medical transport. I know in talking to several of the personnel in the branch, that's a very heavy responsibility to make, to decide that someone who says that they may have trouble breathing or, you know, they don't appear to have any real symptoms, doesn't need medical transport.

There is latitude legally within the District's framework. I had a review done by the corporation council of the ability to deny transport. That is within the legal capabilities of an individual on the street who can decide that it is not necessary. As a matter of fact, even the EMT's on the fire companies can turn the system around and return an ambulance unit to its quarters if it determines that there is either no one there or no apparent need for a medic unit.

It's a part of a problem that was created by the fact that we have 22 million visitors a year in Washington, a lot of whom are not familiar with either Washington or the emergency medical care provider system; and a lot of these people are here for brief periods of time. Even some of them don't speak English very well. That's part of our international community.

Part of what is necessary, I think, on a system—while you cannot—We can educate a number of our own citizens about the requirements for emergency medical services. We also have just to recognize the fact that we do have some unique call population characteristics, and part of that means that, while Ms. Rolark and you may disagree with how you categorize a priority dispatch system, you have to ask several questions about—When somebody simply calls and says I need an ambulance, there has to be a second question about what is the problem. If it's that I've got an appointment at the clinic and I can't get a taxicab, the answer has to be that's not necessarily a medical emergency. You ought to call such and such and transfer immediately to 8DC-HELP or another service.

There has to be some call screening at that point. Just because we have so many people who are so new to Washington or even to

emergency medical services, we have to be able to make some distinctions on the front end. We admit that there is an absolute necessity for balance about how much information you try and get, but the resources are too important and too critical to be misused.

It's a long answer, but the short answer is: The EMT's in the units can deny transport legally. I think there is an understandable concern about——

Mr. PARRIS. They can or can't?

Mr. DOWNS. Can. There is an understandable concern about what that means for them personally and professionally about making those judgments.

Mr. PARRIS. Well, in practice, Mr. Downs, we're informed that they are not given that latitude. I don't know what your regulations say, but that's what we are told. I will suggest to you that in other emergency service systems around the Nation and other metropolitan areas, there is a medical chain of command, so to speak, in which you can call. There are available people on call to apply trained judgment in terms of headaches versus something else. They use that system, and I suggest that there is no reason why this city should not consider it.

In that vein, is there some reason why the city does not impose a financial penalty of some kind on those persons who utilize this service without—in a real nonemergency? Has that thought been explored? Is there some reason why you don't undertake that?

Mr. DOWN. The fee schedule that is set out, I think, is for an advanced life support unit. It's $70 for a call. Basic is $35—I'm sorry, $55. The problem is sometimes the collection of that fee. We do not provide, as some cities do, free medical—free ambulance transport. Our collection rate, though, as we understand it from a number of systems around the country, is probably one of the highest collection rates in the country.

We have a very aggressive delinquent charge collection system, including at the end turning it over to a collection agent, private collection agency for collection.

Mr. PARRIS. Could you furnish for the record to this committee a listing of the amount of those collections, the percentages and the amount of dollars and that sort of thing?

Mr. DOWNS. Be glad to, Mr. Parris.

Mr. PARRIS. I appreciate it. Ms. Rolark, as you heard, our exchange here indicated, the District has long been criticized for what's called a priority dispatch system; they dispatch units on a priority basis. You alleged a moment ago that you have to ask the next question, and I don't quarrel with one more question, but when you delay the dispatch because of a long string of questions to a generally distraught caller, you get, in my view, priorities backward.

Now in Baltimore, and there's been a lot of talk about Baltimore, they had 140,000 calls in 1986. You had 156,000. They used the direct dispatch procedure with great success in Baltimore. Why doesn't the District of Columbia adopt that system? Just somebody calls and says I got a problem, you say is it a medical problem? They say yes. Now the ambulance run. Why don't you do that?

Mr. DOWNS. I sat in Baltimore's dispatch area for an afternoon. They have 89,000 calls a year versus 125,000 for us; but they also make——

Mr. PARRIS. Mr. Downs, I think that's incorrect, and the purpose here is not for you and I to engage in bantering about exactly whose numbers are precisely correct. What I want to do is get to the bottom of this problem and stop jousting with you. OK?

Mr. DOWNS. I just thought the facts would serve better.

Mr. PARRIS. Well, Mr. Downs, if you'd like us to go into those facts in this hearing, I'll be delighted to do so, but I don't think it serves our purpose. OK?

Mr. DOWNS. In my observation in the dispatch area within the Baltimore system, they do make differentiations. They even make decisions about nondispatch. Their call taking is not simply I want an ambulance. There is a process of determination. Every system that I have looked at, Miami, Philadelphia, New York, Atlanta, Fairfax, all has a way of determining to some extent or another what is the appropriate response.

There are differences even in the kind of medic units versus basic life support units that you dispatch; and the medic unit, being the most valuable resource that you have within the system, is therefore the one that you want to make sure that you've targeted to the right area of need. There's nothing worse than having an entire system that is responding someplace that it should not be when the real call comes in.

I don't think anybody has said in the past that there was a mistake in the detail within the priority dispatch system and that we have tried to simplify that by working through with the people who should know best, and that is the hospital based providers, the EMS—a number of people from the EMS committee, but particularly people from the emergency rooms themselves who should know best about how to handle this kind of situation.

It is the medical arena where I'm more comfortable deferring to the individuals who have to make these decisions daily about life and death.

Mr. PARRIS. Mr. Downs, on page 8 of your testimony you make reference to the fact that among many of the Nation's major metropolitan areas there is 0.8 dispatchers for every 10,000 calls, and the ratio in the District of Columbia was .3 per 10,000 calls. Back in April there were newspaper accounts of the Mayor's announcement that 15 additional dispatchers were going to be hired. Have they in fact been hired? Are they now on the job?

Chief COLEMAN. That is correct. They have been hired, and they are now on the job.

Mr. PARRIS. And they are in the process of being trained. Is that correct?

Chief COLEMAN. That is correct.

Mr. PARRIS. We will hear some testimony from Ms. Sperling, a representative of the ambulance dispatcher union on that matter later in this hearing.

On page 9 of your testimony, Mr. Downs, you make reference to the task force report which I read from earlier in my comments, and you say that the task force issued a report "quite critical of the operations of the emergency ambulance service." You go on to say

that the report has mixed reviews, particularly from the fire department, and so forth.

Now that should not be very surprising, inasmuch as the report was fairly critical of the fire department management system. Of the deficiencies, 82 of which were listed in that report, how many have been addressed, and how many have been implemented? Can you tell us?

Mr. DOWNS. Mr. Parris, I could not tell you to a number. I would have to go back and pull each of those off that and run it against the 130 some odd that we agreed to as management improvement steps, to see how many of them have been accomplished. A significant number of them have. I just could not tell you the number.

Mr. PARRIS. Has the task force report been formally released to the public?

Mr. DOWNS. I'm not sure formally. I knew that all three TV stations, the Post and the Times had copies of it. I'm not sure that's formal, but——

Mr. PARRIS. You made reference, I think, not in your testimony but in your oral comment, that a nationally renowned emergency service director, or words to that effect, was in the process of being hired. My question—I congratulate you for that. I hope he arrives soon. I assume he will be subject to the residency requirement.

Mr. DOWNS. He would be.

Mr. PARRIS. Has that requirement delayed your acquisition of appropriate applicants for that job, Mr. Downs? I can anticipate your answer is already no, but I suggest to you that might not be totally without some prejudice on your point of view.

Let me just ask a couple more quick questions, Mr. Downs. I have no interest in engaging in a great semantic exercise here.

My sources indicate to me that 21 ambulance services—21 ambulance units—excuse me—as indicated on page 13 of your testimony, have been placed in service with "five fully staffed reserve units." I am, I think, reliable informed, those five reserve units are essentially skeletons. Is that an overcategorization, unfair categorization, in your view? What happens when a unit in service gets transferred to another ambulance unit and they have to spend an hour taking all of their gear out of that unit, going to another one? I don't call that a real reserve unit. Is that just an unfounded concern on my part? Is that—Are those reserve units what are supposed to be in reserve, and could they be better utilized if there were more ambulances?

Let me add this categorically, and to his credit. I discussed this with the Mayor at some length, and he indicated to me that there was, I think, eight or so new ambulance units on order, under contract, words to that effect. I congratulate you for that. I do not mean in any sense to issue a blanket indictment of the persons who serve in the service of the city's efforts to improve it, that sort of thing. That's not my purpose here, but I do have strong opinions that the service can be improved.

Now the question, and it's a long question perhaps, are those reserve units really reserve units, or are they—Is that a priority of the city?

Mr. DOWNS. I'll ask the chief to respond, too; but on the front end let me say that in honesty a number of months ago the reserve

units were in essence skeletons that were kept at the apparatus division, not really available in a timely fashion to the crews, and it was not unusual for it to take an hour to transfer oxygen and other equipment out of an out of service ambulance and put it into a new service ambulance.

The five that are now available are fully equipped, unless there has been some kind of down on a unit and they needed some reserve. They are fully equipped and available without this kind of transition that was very awkward in the past about transferring medical supplies and everything else. But I would ask the chief to address that.

Chief COLEMAN. Mr. Parris, I would like to say that you may or may not know that we replace over half our ambulances each year, which means that many of our ambulances are in some operable shape when we replace them. Right now, we have approximately 10 ambulances equipped and ready for service, should we encounter a situation with an ambulance being down.

In addition to that, we have just had 10 new ambulances delivered to our apparatus division, and as soon as radio equipment can be installed those 10 ambulances will be ready for service.

Mr. PARRIS. On the question of the radio equipment, Chief, while I've got you in front of the microphone here, was there some kind of a problem on the antenna or something for those ambulances? Has that problem now been corrected?

Chief COLEMAN. Equipment——

Mr. PARRIS. On the radio equipment for those units?

Chief COLEMAN. Yes. September, we will have the ambulances all equipped. I believe the ones you are talking about are additional communication——

Mr. PARRIS. But it's not corrected yet, but it's in process and in September——

Chief COLEMAN. In September, we'll have it all corrected.

Mr. PARRIS. Let me ask Mr. Downs, on page 10 of your statement you say the new EMS working group has met with representatives of the ambulance and dispatcher union. I just have one very simple question. Why, if you have an emergency medical service working group—why are not the unions that represent people who do that work—Why are they not a member of the working group itself? Is there a reason for that?

Mr. DOWNS. Each—The working group that was established by the Mayor to manage this issue is myself, the fire chief, the commissioner of public health and Mr. Yeldel as the head of the office of emergency preparedness. Mr. Yeldel and several others within the department met with the union representatives to not only keep their input coming but to make sure that we stay sensitive to their needs in this process.

At the beginning of this, not only did the heads of the locals involved in this service from CWA and AFGE and firefighters meet with me and the respective agency heads, they also met one on one with the Mayor so that he could hear directly about their concerns; and the Mayor pledged at that time his administration's full cooperation with them in trying to improve the service and to stress the importance of not celebrating our differences but to celebrate success about solving the problems within the service.

We started consciously with the approach that the people who have to make the system work are the people who ride the units every day, and they're the people who have to have the first input and the last say on what is working and not working within the system.

We're not insensitive to it, and want to keep that commitment a part of our overall philosophy. It's why the Mayor, in changing the structure of his own EMS committee, changed it to include representatives from each of the three unions on the committee, so that they have a policy voice with the physicians at the hospitals, with the fire department, with others who provide this service throughout the community.

Mr. PARRIS. Well, I have no desire, as I've indicated earlier, Mr. Downs, to engage with you or anybody else in a semantic exercise; but to call that a working group seems to me a little overstatement. I would call that a committee of the internal administration of the city who get together once in a while. And to put a committee of the foxes together to examine the quality of the chicken coop is not my idea of a working group.

Now having said that, I wonder if I could ask, Mr. Downs, if you would give this committee a—furnish to us a report on or before, say, November 1 of this year and perhaps the first of the year, an update on the status of the EMT and CPR certification programs and that sort of thing on the EMS, a kind of a running report, if you would, as to how you're doing. I'd be grateful for that. I think the chairman would, and we would be appreciative if you would do so.

Mr. DOWNS. Be glad to.

[The above report was not received in time for printing.]

Mr. PARRIS. I appreciate that. Let me—Mr. Chairman, I won't take a lot more time here. I'm constrained to suggest to you that we've had a number of media observations going back as late as February 1981, in the Washington Star which was then extant, which says the ambulance chief quit, cites cut; city ambulance service is in such bad shape, I'd be concerned if my father had a heart attack in the city, et cetera.

On March 2, 1981, the newspaper headlines warned that the new report assails city rescue service, lives threatened, et cetera. This is not a new problem, and I would suggest to you, Mr. Chairman, and I would ask unanimous consent to insert in the record a memorandum prepared on April 23, 1984, by a gentleman named William L. Mulligan who was then the deputy fire chief, charged with the emergency medical service.

He says, among other things, "At present, the organizational structure of the division is fragmented and does not reflect proper administration or management."

That was on April 23, 1984, and a couple of weeks later he was fired; and I suggest with all respect it may have been that he was not terribly enthusiastic about the way he was being assisted in the administration of the department over which he had responsibility.

Nonetheless, Mr. Chairman—last one—in the Washingtonian Magazine, March 1984, it says send an ambulance right away. And in the balance of the article it gives advice on what to do if you've got seizures and chest pains and all that other good stuff, how to

survive a heart attack. This is not yesterday. This is 3½ or so years ago.

So this will never be a perfect solution to the world's problem, but I—Where it's been accomplished, I congratulate the city for its improvement. Where there are still shortcomings, I wish it well and urge that this emergency service program receive a higher priority than it has in the past.

I thank the Chairman for this opportunity to question these witnesses this morning. Thank you.

Mr. FAUNTROY. Certainly. I will certainly not object to the inclusion of those 1984 documents in the record. I think it will make a good comparison to both the substance of the report at this hearing as to the status of things, and will be a good reference for the data you've asked with respect to training to be provided at the end of the year.

In that regard, I would simply extend this questioning period to have the witnesses reiterate and give an interim report on the findings of the Mayor's emergency medical services advisory committee that you cited about the level of certification in the fire department at the time of the report, and what has been done since.

So that, would you care to comment, Mr. Downs, as you did in response to a question which I gave—I raised with you, to the report that more than 1,400 members of the fire department had no certification in CPR?

Mr. DOWNS. As I said at that time, Mr. Chairman, Mr. Parris' statistics were right as of the time of the report. The indication of the seriousness with which we took the issue is measured by the fact that, of the 1,271 firefighters that we have on board actually, over 1,000 of them do currently have CPR cards as a result of training and certification that's taken place since the report.

Mr. FAUNTROY. So that the fact is that there are not 1,434 members of the fire department, but 1,271; and the number trained in CPR and certified thereto are not zero, but that number is now 1,000 out of 1,271?

Mr. DOWNS. That's true, Mr. Chairman.

Mr. FAUNTROY. Thank you, for the record; and I hope that you can demonstrate at the close of the year an equally as impressive improvement in response to legitimate concern, not only of Members of the Congress but of citizens of the city, that the emergency ambulance service respond to the needs of the people.

Thank you so very much.

Mr. DOWNS. Thank you, Mr. Chairman.

[The articles furnished by Mr. Parris follow:]

D.C. - 44
APRIL 1982

Memorandum ● Government of the District of Columbia

TO: T.R. Coleman
Fire Chief

Department, Agency, Office: Fire EAD

FROM: William L. Hullikin WLH
Deputy Fire Chief

Date: April 23, 1984

SUBJECT: Initial Evaluation of Critical Deficiencies relative to the Delivery of Emergency Medical Services to the Public

In evaluating the delivery of emergency medical services to the public by this Division I feel there are several areas of concern which are in need of immediate attention due to their critical nature.

The items listed here are the most important items which should be addressed as soon as possible in order to maintain an acceptable level of efficiency and patient care.

1. Organization of the Division - At present the organizational structure of the Division is fragmentated and does not reflect proper administration or management. Recommend the following organizational structure be adopted (Figure 1). This is in keeping with the administrative structure of the Fire Department and other established EMS systems throughout the country.

2. Medical Supplies - At present there seems to be a great deal of confusion surrounding the purchase and disbursement of medical supplies for operational units. In investigating the claim of shortages of several items it is reported that funds are not available to meet the demands of the service.

Under category 0104-23 (ambulance and first aid supplies), $110,002 was allocated for the present fiscal year with $40,000 being reprogrammed into administrative reserve. $10,000 of this administrative reserve was returned to the supply category just last week. As of March 31, 1984 $77,386 has been obligated ($11,055 per month), leaving a deficit of $7,386. This leaves $2,614 for the remaining five months of this fiscal year for medical supplies. As of this date the following items are out of stock and are needed by operational units:

Elastic bandage 3"	ordered 2-2-84
Suction catheter	ordered 3-26-84
LPH germicidal detergent	ordered 3-26-84
Non sterile gauze 4 x 4"	ordered 2-9-84
Tape, dermicel 1", 2", & 3"	ordered 2-9-84
Nasal cannulas	ordered 2-9-84
Ammonia Inhalants	ordered 2-9-84

EXHIBIT D

The supply of Narcan, a heavy use drug item, will be depleted in another week. This item will be needed in increasing amounts during the summer months for treatment of overdose patients.

Based on the implementation of new protocols, a recommendation was submitted on February 7, 1984 for the purchase of the drugs Bretylium and Glugagon, and for a new cervical collar, the Stif-neck by Jobst. These items are unavailable at this time due to lack of funds.

Approval has been given for the use of MAST trousers (anti-shock trousers) by all basic units. There is no funding for these items.

From the above information it can be seen that this EMS system is in dire need of additional funding for supplies.

3. First Responder Program - At present there is a critical need to provide adequate medical care for victims in the life threatening category prior to the arrival of BLS and ALS units. The number of certified EMTs within the Fire Fighting Division at this time does not provide each engine company or rescue squad with enough EMTs to insure that one will be available when a fire company is sent as a first responder unit. Routinely units are dispatched on Medical Locals without an EMT on board.

To correct this situation it is recommended that all operational fire personnel be required to complete the First Responder Program. This level of care would be in addition to the present level of EMT certification which should be maintained.

Mr. Danny R. Mott, the Training Coordinator has submitted a request to implement this program on three separate occasions over the past three years.

By addressing these concerns at this time we will demonstrate our commitment to effective management and operational efficiency.

Organizational Chart, Emergency Ambulance Division

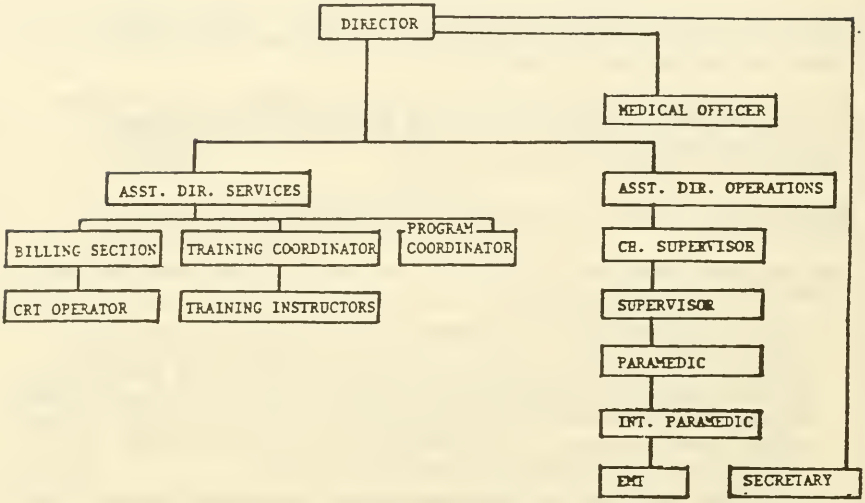

Figure 1

[From the Washington Times, May 20, 1987]

911 System Absolved of Blame for 12-Hour Neglect of Body

(By Adam Sommers)

The chairman of the House District subcommittee said yesterday that human error was responsible for the body of a Georgetown University law school student to go unattended for 12 hours April 30 despite repeated calls to emergency personnel.

"The 911 system worked, but the people in the system had some failings," Rep. Julian Dixon, California Democrat, said after the subcommittee examines the incident and the operations of the city's 911 emergency system.

In response, Assistant Police Chief Melvin High testified that police are improving their communications procedures, which were part of the reason for the delay.

Subcommittee members also examined a separate May 13 incident in which a caller said a dispatcher hung up on her after she tried to report a fire.

In both cases, Mr. Dixon said, "911 was not an important factor. . . . I am not suggesting that 911 is problem free. . . . But the city is attempting to alleviate the problems."

Chief High testified that the person calling in the fire hung up after a dispatcher said he was going to transfer the call to the fire department.

Joseph Yeldell, director of the city's Office of Emergency Preparedness, said that a clicking noise in the transfer could have made the caller think someone had hung up on her. He said his department is working with the telephone company to eliminate the click and that the work should be done within two weeks.

Mr. Dixon suggested that to avoid a repeat of the problem dispatchers should use "formula language" designed to keep people on the phone, such as saying, "Stay on the line," right after saying the caller has reached 911.

Chief High said the police department is working on such language, but he had no estimate of when it would be put into effect.

The body of Jan Alexander Stransky Jr., 22, was found in an alley near Dupont Circle on May 1. Police said he had been robbed and shot three times. A suspect was arrested in the case.

Mr. Stransky's death did not attract much attention until it was learned on May 13 that his body went unattended for 12 hours despite several calls about a body in an alley off P Street NW.

Chief High said police and ambulance responded to two calls on the night of April 30 without finding the body, and only discovered the body after getting a specific location from a third caller the next morning. The first and second callers gave only a general location of 16th and Church Streets NW.

Chief High said none of the police responding or the ambulance crews got out of their vehicles to search the area and that none of the police tried to contact the person calling in the incident or asked the dispatchers for more information.

To make sure the same problem does not happen again, Chief High said, if police do not find anything wrong at a reported crisis scene; they are to verify the address with the dispatcher. If the address is correct the dispatcher is then supposed to call the person who phoned in the emergency and get more details.

[From the Washington Times, Apr. 23, 1987]

Ambulances That Need Ambulances: Mayor Barry's Slow Response

After a prolonged nap, Mayor Marion Barry seems to have come awake to focus on, if not yet adequately address, the disarray within the District of Columbia's ambulance service. Well, the awful human toll and the community's outraged reaction are finally penetrating the leadership cocoon.

For openers, it is time for Fire Chief Theodore Coleman to pack it in. The mayor has strongly defended the chief, but whatever extenuating reasons might be advanced for the awful situation here Chief Coleman must, finally, be accountable. He says he's a fighter and won't go quietly. Well, we recall the baseball manager jerking an angry pitcher who demanded to know if there was anybody better in the bullpen; maybe not, the manager said, but there might be someone luckier. Chief Coleman would perform a service by bowing out gracefully. If not, the mayor must push him.

How bad are things? Listen to what a task force from the Mayor's Emergency Medical Services Advisory Committee said in a report last August. Rescue service personnel, it found, "are being hired without appropriate medical experience" and

"without appropriate personal screening interviews and without a minimum command of the English language." The task force, headed by Dr. Harry Chen of George Washington University's emergency medicine department found 82 deficiencies in the areas such as training, equipment, supervision, staffing, communication, command, organization, and hiring. "Apparently, the ability to pass the background clearance and the required drug screening are the only valid criteria necessary for hiring," it concluded.

The mayor and the chief denied, dismissed, and then uttered the usual bureaucratic argle-bargle in moving, very slowly, to acknowledge some fissures might exist. If anything, the problem has since gotten worse. In seven instances reported since September, ambulances have been slow in reaching persons who subsequently died; perhaps even instantaneous response by an ambulance wouldn't have mattered, but that's an unacceptable dice roll. Hardly a day goes by, it seems, without a report of some intolerably delay in dispatching an ambulance, rescue workers getting lost, or 911 dispatchers lapsing in professionalism or a sense of urgency over the phone.

So what's to do? The assignment of a new supervisor for the rescue services (itself a comment on Chief Coleman's stewardship) at least shows movement.

There are some immediate steps that should be taken. First, the current 911 "priority system," under which dispatchers with little or no medical training attempt to make a judgment of relative seriousness before dispatching an ambulance has got to be scrapped. It is made for awful errors and, on the human level, unfair to the dispatchers that have to make these harrowing decisions. A city ambulance should be dispatched routinely. The assumption needs to be that all calls are of equal urgency.

Abuse? You betcha! It has been estimated that 40 percent of the 911 calls for ambulances are for medical "taxi" or at least nonemergency reasons, as Mayor Barry rather crudely observed last week. But the stakes are terrifying when the dispatchers, with the best will in the world, mistake a personal catastrophe for ignorance or laziness.

Other cities automatically respond to all emergency calls. As this newspaper's Adam Sommers and Matt Neufeld have reported in their solid series on the emergency service system, Baltimore and various Washington-area jurisdictions are functioning effectively without a priority system. In Montgomery County, the average response time is just two minutes. In Baltimore City, Arlington, and Prince George's County, it's four minutes. It takes a whopping 10 minutes in the District. If the city wants to deter 911 abusers, it could set up sanctions against those who barrage the system with frivolous calls. This will mean that the city ambulance fleet of 21 vehicles will have to be expanded significantly. How much is one needlessly lost life worth?

Second, the District needs more dispatchers to aid the current 33, who answer about 124,000 calls a year. Mayor Barry's decision to hire another 15, announced earlier this month, is a step in the right direction, if belated. And the Mayor's announcement that dispatcher work shifts will be reduced from 12 to 8 hours will help the situation by reducing stress and fatigue. But these moves aren't enough.

In order to attract quality staffers, the District should at least waive (better to rescind it) the residency requirement for emergency service personnel, one of the key recommendations of the EMSAC task force last summer. The residency requirement for city employees is one of those neat tenets that might be well in an ideal world, but in actuality hurts the city and its people. The mayor needs to face the fact noted by the panel: there simply aren't enough qualified people who can afford to live within the District. Continuing the rigid residency requirement would elevate political sloganeering over efficacious government.

Finally, its a waste that just 30 of the District's 1,300 firefighters are medically certified. While it may not be time—and it may not even be desirable; that's arguable—to repair to the old system of having firefighters provide emergency medical services and rotate on ambulance duty, they are a resource wasting. The paramedics who man the city's ambulances are motivated individuals. We wouldn't question that. But there aren't enough of them available at the right times now. To augment the paramedics with firefighters certified as emergency medical technicians could fill those additional ambulances that need to be bought and brought rapidly into service.

What the District now has is not just a dysfunctional system, but a positively lethal one.

D.C. Firefighter

(By Matt Neufield)

A Washington firefighter said yesterday that he was ordered not to work in the Fire Department's communications center anymore—one day after he spoke to the Washington Times about staffing shortages at the center.

"I didn't do anything wrong up there," said Skip Bingham, a 15-year employee of the Fire Department who said he has worked part-time in the communications center for about 14 years. "I haven't made any mistakes."

Mr. Bingham said he received the order yesterday when he arrived at work. The order came from Assistant Fire Chief Howard Dixon and did not provide a reason why it was given, he said.

Chief Dixon could not be reached for comment yesterday.

"If members of our [union's] bargaining unit are starting to be singled out for criticizing the department, we're not going to take it," said Kenneth Cox, vice president of Local 36 of the International Association of Firefighters, which represents most city firefighters. "We're going to defend their right to free speech."

Mr. Bingham made his remarks Monday to the Times in reference to a staffing shortage at the department's communications center for more than nine hours Sunday. The center operated from about 9 a.m. to 3:30 p.m. with seven employees instead of the usual nine assigned for a 12-hour shift.

The disclosure of the staffing shortage occurred three days after it was revealed that Fire Department management and the union representing dispatchers were embroiled in a controversy over the status of 15 dispatchers who are allegedly in violation of the District's residency requirement and if so could be fired.

The city contends it could afford to lose the 15; the union disagrees.

Yesterday, Mr. Bingham said he could lose about $7,000 in overtime pay if he is not allowed to work in the communications center. "It makes me angry. It makes my wife angry," he said. "I've got a family to feed."

"I've never been reprimanded for anything I've done up there," he said.

"If we see a pattern developing where our members speak on deficiencies of the department and are reprimanded, we're going to take appropriate legal action," Mr. Cox said.

[From the Washington Times, Apr. 23, 1987]

GOP Lawmakers Seek Ambulance Hearings

(By Gail A. Campbell)

The four Republican members of the House District Committee are exerting pressure on D.C. Delegate Walter Fauntroy to get him to hold hearings on the crisis in Washington's emergency ambulance service.

Mr. Fauntroy's most recent announcement was that he believed city officials can handle the situation without congressional interference.

But a letter signed Tuesday by Reps. Stan Parris and Thomas J. Bliley Jr. of Virginia, Stuart B. McKinney of Connecticut and Larry Combest of Texas urges Mr. Fauntroy to reverse his position and convene his subcommittee for hearings.

"As members of the Committee on the District of Columbia," the Republicans wrote, "we are deeply concerned over recent and continuing reports of problems within the city's emergency ambulance service. . . . Some of us have been approached by colleagues who have had a constituent die as a direct result of these problems, and still others who have experienced substantial response delays after dialing 911."

A spokeswoman for Mr. Fauntroy said he received the letter and will formally respond to the committee and issue a statement later.

Mr. Parris, the ranking Republican on Mr. Fauntroy's subcommittee, said if "three or more members of the committee ask for the hearing, under the rules of the House and Congress, we can press for it."

"We think that it's compelling for the Congress to exercise its oversight," Mr. Parris said yesterday. "We have hundreds of thousands of people coming here every year whose safety could be in jeopardy."

"If nothing else, they [hearings] could educate the members of Congress about what is going on and why, and give city officials an opportunity to explain what they're doing about it." Mr. Parris said.

A firefighters union member said only pressure will make the city take meaningful action.

"When some ambassador, congressman, senator or other dignitary gets hurt and an ambulance is delayed, then you'll see some changes," said Thomas N. Tippett, president of Local 36 of the International Fire Fighters Association. "The right person just hasn't died yet."

[From the Washington Post, Apr. 7, 1987]

FIX 911—IT'S AN EMERGENCY

We protested about it last May, and many times since: the city's 911 emergency number is a Class-A, all-points disaster. It is a matter of life and death that the operation isn't functioning properly—and it must not be explained away in a fog of bureaucratic answers. People have died while those calling for help were being grilled about the precise nature and seriousness of the illness or injury in question. Though "cause of death" is not ascribed to "late ambulance," that horrible thought is haunting more than a few families—and one family is too many. Even putting aside any employee who may be personally and individually at fault in any one case, the service as it has been conducted is a municipal outrage.

D.C. Council Member John A. Wilson got to the point at a hearing last week, in words addressed to Fire Chief Theodore A. Coleman: "Chief, something has got to be done. We can keep belaboring it, [but] it is grossly embarrassing. It's time to get it together, Chief, I don't think there are any more excuses I care to offer for the service, and . . . I don't think you should offer any more excuses for the service. It's our fault, it's not the public's fault."

Mayor Barry and Chief Coleman keep pointing to the fact that there are more than a million calls to 911 every year, and that some 40 percent of the ambulance calls are not emergencies. The city tried to address this eight months ago with a "priority system" for dispatching ambulances: dispatchers, who have not been required to have medical training, are supposed to figure out how high a priority each call should get. That may seem workable on paper, but it's an absolute calamity in practice and an unfair burden on these employees.

What should be done?

Every call should be answered immediately. Baltimore and other cities use this direct approach, and it is the only way to respond. Any error must be on the side of life, not death.

All personnel—on the phones and in the ambulances—should be better trained. Rescue teams should be combinations of younger employees and more skilled veterans.

The non-emergency police and ambulance number should be publicized more. For this help, people should call 8-DC-HELP.

People who abuse the 911 system should be billed and/or fined. Using 911 as a taxi service is a rotten offense.

We realize that the latest series of events has been hard on morale in the emergency services, and that there are many men and women giving their best to this terribly important job. They need all the support they can get—not excuses or procedures, that get in their way. Mayor Barry now says many of the improvements will be made. But even "will be" is too late—this is an emergency.

Mr. FAUNTROY. We are going to continue the hearing, if you do not mind. I've asked that, inasmuch as Mr. Harry Teeter is not here, I'd like to ask Dr. Howard Champion, who is the chief of trauma and .director of the surgical critical care service of the Washington Hospital Center, would come and give his testimony at this point. Then we will resume with the distinguished wife of Congressman Cass Ballenger.

TESTIMONY OF HOWARD R. CHAMPION, M.D., THE WASHINGTON HOSPITAL CENTER

Dr. CHAMPION. Chairman Fauntroy, I thank you for asking me to give this testimony. I thank you for allowing me to come out of time. With your permission, my staff, Ms. Midge Moreau, will sit

next to me in case I need to respond to specific items that are out of my immediate scope.

My written testimony has been handed in, and I have identified the problems that were clearly brought to the attention of the community over a year ago. I would like to compliment Congressman Parris on the command of the problems and concerning facts with regard to the EMS system here in the District of Columbia.

I think the District of Columbia runs an outstanding police department, an outstanding fire department, and an unfortunately very poor ambulance service. I think that it is clear that the departments that are well run by the city are run by experts who have been trained in that field and have developed their expertise over a number of years.

Part of the problem is that the ambulance service is an emergency medical service, and it is currently managed as a poor sister of the fire department, as it has been for a number of years. I have been working in the city for over 10 years and, when I first came here, the ambulance service was not even a line item in the budget of the District. After a number of efforts, we began to focus attention some 10 years ago on improving the service then.

The Congressman has identified the key problem, and that is that there is a lack of confidence in the service, and the reason for this is that there is a lack of confidence in the ambulance service by the medical community. The medical community has been working for a number of years with the fire department to try and improve the ambulance service, and has been working in an uphill fashion in many facets.

I welcomed the input of Mr. Downs a number of months ago when the executive branch of the government assumed what I would regard as a responsible position with regard to the fire department operation of the ambulance service. Mr. Downs, from knowing very little about ambulance services, has learned an awful lot and has brought superlative management skills to a very real problem.

As time goes by, as month after month goes by, I find myself agreeing more and more with what Mr. Downs is saying and his ability to address the problems. However, I feel that we have danced around quite adequately in many facets of the problem, and in many cases we are getting lost in minutae.

It seems clear to many of us in the medical community that the fire department is still, after all of the efforts that have been made, not responsibly capable of running an emergency medical service for the citizens of the District of Columbia.

We would like to recommend that the ambulance service be removed from the fire department. The management structure in the fire department is not appropriate for an emergency ambulance service. The ability to provide a fire truck manned by the unwilling unqualified is not a state-of-the-art response to the emergency needs of those that get ill or injured in the District of Columbia.

It is quite adequate in many cities to provide an emergency ambulance service as a hired out service using common 911 access and providing adequate vehicle maintenance and communications and housing with fire departments.

I challenge the statements by Councilwoman Rolark that it is commonsense to provide an ambulance service through a fire department which provides an excellent fire service but has yet to prove to many of us that it is capable of responding to the emergency needs of the citizens of this community.

We need, I think, an ambulance service headed by somebody who is competent at running ambulance services, and I am glad to hear from Mr. Downs that this is on track. We need medical control, advice and guidance on the emergency medical service. The state of the art in emergency medical services in the United States is advanced life support. The current level of advanced life support availability, timely availability and quality is deplorable in the District of Columbia, and it is no answer to say that EMTs on fire trucks are providing that service. They do not provide that service.

We need appropriate dispatch, and I think many of these issues are being answered by the management approach of Mr. Downs. We have yet to be convinced that the daily meetings that are occurring between the commissioner of health and the fire department are a productive exercise. I would state that they are the first step in a quality assurance exercise in that they are a quality care assessment exercise.

I think Dr. Coleman-Miller and the commissioner of health have done everything within their power to bring to bear medical oversight to the emergency ambulance service. We are not confident that that is adequate at the present time. They review the run sheets. They identify the problems. They communicate those problems to the fire department, but there is no evidence that appropriate action takes place within the fire department as a result of identifying these problems.

The message is passed up, but I'm not sure that it is received in an appropriately cooperative manner, or that they are able to make the judgments as to what is desirable as a result of this information going back; because there is nobody there that is adequately medically trained, and we are allowed no initial comments in the surveillance of the medical system that is being run out of the fire department.

So a system may be established to assess the problems of patient care, but closing the loop to assure quality care is still far from achieved.

I will just close briefly. We know that emergency medical services are advancing throughout the country, that they are a problem in many jurisdictions. It concerns me that we are muddying the waters by identifying that there are problems in other cities. We are well aware of those. I don't like to see dissemblance in the responses that we should do more than we are doing. I have been sitting in the back there for a couple of hours. I have seen heads shake in disbelief as some of the statements have been made, because they are not perceived as reality by some of those who are working in the field.

I think the more distant one is getting from the executive office toward the field operation of emergency medical systems, the less likely some of these steps have been seen to be effective. Notwithstanding that, I do underline and compliment Mr. Downs and the

efforts of the commissioner of health in trying to address these problems.

I don't think they will be fully addressed until we recognize that emergency health care is different from providing a fire service, and give it the priority and profile in municipal services that it clearly must enjoy if we are going to be proud of the services that we are delivering.

I will end and thank you for this opportunity to emphasize some of the potential areas of solutions rather than dwell on the problems that many of us feel really do exist and must be addressed in a responsible fashion.

[The prepared statement of Dr. Champion follows:]

TESTIMONY OF HOWARD R. CHAMPION, M.D.
CHIEF, TRAUMA SERVICE
DIRECTOR, SURGICAL CRITICAL CARE SERVICE
THE WASHINGTON HOSPITAL CENTER

In July 1986, after 3 months intensive study of the District of Columbia's Fire Department Ambulance Service, a task group report was presented to the Mayor's Emergency Medical Services Advisory Committee. This report, prepared by experts in the field of emergency medicine and prehospital care, carefully outlined the major deficiencies within the system and setforth recommendations to correct these deficiencies.

One full year later, we are no closer to fulfilling these recommendations. Indeed, if another task group probe were mandated today, the system would be found to be substantially weaker in many areas previously scrutinized. In the conclusion of the task group report, the members stated "some of the problems identified are obvious and too urgent to allow significant time to pass without further deterioration in provider morale and patient care." These words, as others from the report, have returned to haunt us. Few days go by without occurrence television, radio, and newspaper coverage of yet another unusual occurs within the ambulance service. Incidents of ambulances being lost in route to a call, ambulance dispatch times being higher than the national average, law suits stemming from alleged inappropriate interventions by prehospital providers have become the daily fare. National and international news agencies and medical journals have begun to carry the stories relating to what one such article described as the "Crisis in the Capital." The city government, the fire department and the medical community have alternately fought over the issues, ignored the issues, and even tried at one time to bury the issues. The issues, however, remain prominent and unchanged.

- there is no medical accountability as reflected by no daily audits of the run records, no counciling of the providers, nor follow-up on the patient.

- there is not adequate initial training nor continuing education provided to maintain the knowledge base and skill performance levels needed among providers to adequately care for the citizens.

- the "residency requirement" has greatly depleted the applicant pool thereby greatly reducing the number of eligible persons who could be hired and trained for the job.

- In field medical supervision which should be the cornerstone upon which a system it is built is non-existant.

- the present priority dispatch system is woefully inadequate. There are no formally DOT trained dispatchers nor is there a formalized evaluation process for the communication division call takers and dispatchers.

- there is no adequate methodology for dealing with system abuse. Approximately 43% of the runs on a daily basis are not transported yet these additional runs tax an already stretched system.

- the organizational structure which has seen 14 uniformed fire chiefs run the service in the past 12 years needs total restructuring to allow for strict civilian management along with a highly visible and knowledgeable medical control physician. These individuals should not report to the fire chief, but perhaps to an outside body such as the Commission of Public Health who will provide ultimate oversight.

The lack of commitment to emergency health care in the Nation's Capital is a disgrace and a health hazard and has received television play as far off as Madras, India.

The dying, disabled and sick are clearly a low priority. We call on this Committee to stimulate a response from the D.C. Government.

Mr. FAUNTROY. I want to thank you, Dr. Champion. Your testimony has been most instructive to the committee and to the Members of Congress. I'm particularly impressed with your reference to the historic lack of confidence on the part of the professional medical community in the emergency ambulance service and with your acknowledgement of the growth, not only of Mr. Downs, but of the District executive branch in coming to understand the need for improvement.

I am particularly interested in two things that you referenced in the latter part of your testimony. One is the fact that, while some statements were being made as indications of steps being taken to address the problems, others were shaking their heads, because at the level where the rubber hits the road the impression is not that those steps will deal with the problem.

I wonder if you would search your own memory of this morning for one or two instances where statements were made where you feel the experience at the operational level would not justify the confidence that—with which the statements were made as addressing the problem.

Dr. CHAMPION. Well, I think I referred to one in some detail, and that is the medical control and oversight where I think it was indicated that the daily meetings were an answer to the problem, and I think I explained fairly explicitly to you that, because a meeting is taking place, because information is transferring in one direction is by no means an assurance that the effector organ is functioning appropriately. I think we have a long way to go, as I said, to assure the medical community that the fire department is being appropriately responsive to the information that is being handed to it on a daily basis by the commissioner of health's office, which is doing a tremendously good job in evaluating the information that it has been provided with by the fire department.

I think another issue that we need to have our confidence bolstered in is that the priority dispatch training is going ahead as it should. I don't know the details, but I think we were told that this was en route. I am not sure that it is en route far enough for those of us to perceive that it is en route to respond appropriately to that statement.

Mr. FAUNTROY. The most pungent point made in your testimony, in my view, is the need to elevate the emergency ambulance service to a separate and more directed level of District government. Is it your view that the civilian head of the emergency ambulance bureau that Mr. Downs mentioned is to be hired in the very near future will improve that situation?

Dr. CHAMPION. I sincerely hope that we will be able to recognize the impact of bringing somebody who has brought some demonstrated skills in managing an ambulance service into the ambit of that service into the fire department. If we don't, I think we've got real problems.

I would just point out that individual is still answerable to the fire chief. That in terms of management specifics to address a problem of patient care that might involve discussing it with communications, ambulance dispatch equipment, the ambulance service itself and others, that means that the individual has still got to coordinate a great constellation of chiefs and go through the fire

chief to bring those various operational elements together to discuss a problem in the fire department.

You cannot effect single step management the way the fire department is currently constructed, and until the individual has authority to operate an ambulance service, not just a ring of a much larger fire department with some control over the allocation of budgetary personnel resources and responsiveness of the very elements that provide the service, I don't think we're going to see a good service.

I have been continually concerned that the fire chief who, I must say, operates an outstanding fire service, from what I can see, has not been responsive to the management and medical problems that have been brought to his doorstep. I cannot see, given the fact the fire chief is there and is staying there, that the ambulance service can improve to the level that we would be happy with, unless it is given the priority to control its resources and provide a service; and I don't think that can happen in the fire department.

Furthermore, I think it should have the priority in the city administration to the effect that the Mayor and the executive office and the city council know that this is a priority for the community, that it has its own budget, that it has its own pointsman, and we're not ducking behind various layers of what we all recognize—at least, most of us do—as incompetently led management with regard to the provision of timely, state of the art, 1988 or 1987 emergency medical services.

I would point to new elements that continue to undermine our confidence in that. I have no confidence, if I have a heart attack or that I am ill or that I want an emergency response, that a fire truck manned with individuals whose mission in life is providing firefighting and who have been told to provide this service as an appendix to their firefighting skills is an adequate state-of-the-art response for the Capital of the free world. I don't think that's good enough, and I will not think it's good enough until we have timely, available—availability of emergency medical services by which many of us in the medical community would regard as adequate.

Mr. FAUNTROY. You make a very persuasive argument. Have you made that argument to the Mayor's emergency ambulance service task force?

Dr. CHAMPION. The task force or advisory committee?

Mr. FAUNTROY. An advisory committee, yes.

Dr. CHAMPION. We have mentioned this a number of times. I think, as the frustration has mounted over the years—Let me step back a little bit. I think this has been brought up a number of times, and we have agreed to try and work within the current system. I look back now on 10 years of attempted cooperative effort between the medical community and various elements of the various people that have been involved in emergency medical service development.

The emergency medical services advisory committee has discussed on a number of times the need or the possible need of pulling the ambulance service out of the fire department. The commissioner of health asked the Medical Society of the District of Columbia to chair a special committee on the ambulance service. That committee recommended to the commissioner's office, and presum-

ably that recommendation went somewhere, that the ambulance service be pulled out of the fire department.

I don't think that it is going to be possible to say that this recommendation has not been discussed with various members of the executive, including Mr. Downs, because I've had meetings where he has discussed this; but you've heard his response today. We remain unconvinced that this is an adequate response, given the level of cooperation, the level of insight, the level of negative responsiveness that we see coming from the fire department.

Now if the fire department were responsive to the initiatives, wishes and, as expressed, the physicians with expertise in this community, it would be a different matter. But that still is not adequately in evidence by a mile.

Mr. FAUNTROY. My final question is: In your experience of independently funded and managed emergency ambulance services elsewhere in the country, how are the coordinating advantages that have been cited by the executive here today accommodated?

Dr. CHAMPION. I am not sure I understand your question, sir.

Mr. FAUNTROY. If I recall, Mr. Downs is making the point, as was the fire chief, that there are a number of supporting services and emergency backups that are present because the service is attached to the fire department. I wondered whether it has been the experience in independently funded and operated and managed emergency ambulance services that would satisfy your need for the kind of confidence required for emergency medical care, whether there has been a coordinating function set up that works.

Dr. CHAMPION. I think there are—Well, first of all, throughout the United States there are a whole variety of ways of a community biting the bullet with the community need to provide an adequate emergency ambulance service, and it can be done by municipal services, by private services, by contract, by all sorts of combinations of those. I think each community must tailor its resources and its ability to provide those services to what it can best do.

I think the medical community in this city feels that the fire department has provided us with a number of years of consistent frustration in not providing the services we want to see in this community, and we feel that this community deserves. It is unfortunate, because we have worked for many years with a consistent need to work with the system. I mean, I think, you know, the frustrations that we have all felt just cannot be expressed in the limited time that you have today to hear from myself and my colleagues who provided this task force.

I think that the potential advantages of an individual service in this city are two, one internal and one external. The internal ones, I've already identified, that it would have a management ability to command its own resources and budget, provide the single—and that would direct itself to one single task in life, and that is to provide emergency medical service.

The purpose of the fire department in the city of Washington is to provide fire services. Also, and way down somewhere on the list, is emergency medical services. If the fire department were to reverse that order and say sick people are more important than firefighting abilities, I would go along with that. No problem. But I believe that, until the fire department says our first priority is emer-

gency medical services, we also fight fires in buildings, then I will continue to have a problem with it.

Once you command your resources and you've got an individual who has some demonstrated skills in managing an ambulance service, it is extremely unlikely that the medical community will not develop confidence in that individual. I think those are the problems; and once the medical community has confidence that the management is directed at providing a state of the art emergency medical service, I think all of the problems will go away overnight.

Mr. FAUNTROY. Thank you. Mr. Parris?

Mr. PARRIS. Thank you very much, Dr. Champion, for your testimony. It would not be constructive to engage in the District of Columbia bashing here. That is not my purpose. I know it's not your purpose. But I cannot resist the temptation to share with you the high frustration level that I sometimes have in dealing with this problem. It's very much like punching a feather pillow, and it is in fact frustrating.

Thank you for your suggestion. I think it's extremely well made in so many ways. When you say, if there is a difference in judgment here, it is in the prioritization of emergency medical services and the need therefor as compared to other municipal services in this or any other municipality. That's where the judgment differences, I think, enter into it here. I thank you very much for your testimony in that regard and for your statement.

Let me just—just a couple of quick questions. You state in part in your testimony—and I'm confident from your statement that you are familiar with the July 1986 task force report and the information that it contains—you state in part, "If another task group probe was mandated today, the system would be found to be substantially weaker in many areas previously scrutinized." Essentially, I think it's fair to say, criticize to a degree in varying aspects of the original task force report.

So if I interpret what you're saying here correctly, what you're really saying is that the situation is not any better and perhaps could be considered as worse than when it was reported by the task force report in July of 1986. Is that a fair summary?

Dr. CHAMPION. I think so, sir. I think the management problems still remain. The person who is heading the ambulance service in the fire department has been here before. The quality of care is being assessed, and there are many, many problems in quality of care. But we are very uncomfortable that any change has taken place, and now these are very recently being identified by a physician.

I think the morale in the ranks is deficient. I think the willingness of the individuals who head the ambulance service in the fire department, the fire department itself to say that we will develop an ambulance service that abides by national standards, attain and sustain those standards for this community so far has not emerged. And I have complimented the management analysis skills and the ability of Mr. Downs to look at a problem and get information and begin to address it in a systematic manner, but time is passing and many things are slipping away as we continue to go from one mode of analysis-paralysis to another mode of analysis-paralysis, suck the bullet instead of biting it and say we want a quality service here,

instead of looking at ways of dissembling and bringing in statistics that say we're not quite as bad or as awful, but we're almost there, and this sort of thing.

You know, somebody has to stand up and say we want the best for this city; we need leadership in the fire department to do it. We need that leadership to have the confidence of the medical community. Otherwise, it's not going to work, period; and move from that point forward.

Mr. PARRIS. I know you have a time problem, Doctor, and we have another vote coming on the floor. The bells have already rung. Let me just ask two very quick questions.

Are you saying in another portion of your testimony, " . . . field medical supervision is nonexistent." Would you still stand behind that statement as being essentially correct today?

Dr. CHAMPION. Could I ask my expert on my right to answer that question, sir? I think the answer is yes, but she could probably, if you don't mind, speak from a different level of insight than I have.

Mr. PARRIS. Ms. Moreau, one of the editors—Is that the correct word?—of the original task force report. Correct?

Ms. MOREAU. Yes, sir. As far as in field evaluations go right now, truly in the field there is not a lot of direct supervision. There are two supervisors per shift. They are very rarely on the scene to oversight direct medical care delivered. They have management things to do, paperwork to do, files to get out, et cetera.

There is an evaluation process for the advanced life support personnel whereby they must be ridden with, and it had been proposed that they be ridden with periodically throughout the year to make sure that their skill levels were maintained; but because of the decrease in number of persons identified to do those evaluations, they are generally done sort of right at the end before their time of recertification is done.

So they can go for long periods of time with no direct infield supervision or oversight.

Mr. PARRIS. Last question. Is the residency requirement a good or bad idea, in your view?

Dr. CHAMPION. I don't know enough about the implications of that to give you a personal answer to that, I'm afraid, sir.

Mr. PARRIS. Would you agree that it has greatly depleted the applicant pool?

Dr. CHAMPION. Well, that's what I don't know personally. You know, I know that we have to get qualified individuals into the service. I'm not close enough to that issue to respond to it, to be quite honest with you. I just don't know enough about that issue, its ramifications and what's going on. Now, Midge maybe could answer that, but I can't give you an informed answer on that.

Mr. PARRIS. Well, that suggestion is made in the report, in the task force report; and I assume that there's been no dramatic abandonment of that attitude, is there?

Ms. MOREAU. No. At the time of the task force, and even today, we felt very strongly that either deletion of the residency requirement or a relaxation of the residency requirement might bring into the community a larger pool of applicants. We found, when we were mandated to do the task force report, that one of the things that we had were decreased numbers of individuals coming into the

system, especially at higher level training, plus those people that were within the system weren't getting the quality of initial education that they needed to bring them up to level.

So we felt that if they could at least relax the rules for a while, allow us to increase the number of the pool, we might have better chances of increasing the numbers.

The other thing is, they aren't recruiting at the IP and P level. There is no job announcement. So we don't even know if we could get people in with or without the residency requirement. But the task group felt very strongly that, if they could relax those rules, it would help us increase the numbers and provide a higher level of care.

Mr. PARRIS. I thank you, Mr. Chairman. Ms. Moreau is, as I say—perhaps a better word is coauthor of the task force report; and Dr. Champion, as we know, is chief of the trauma service, is a recognized national expert on emergency medical services. I thank you very much for your contribution. Thank you, Mr. Chairman.

Mr. FAUNTROY. I thank the gentleman.

We are going to now ask that Ms. Donna Ballenger, the wife of the distinguished gentleman from the 10th Congressional District of North Carolina, would come forward now to present her testimony. As she comes, let me apologize for the length of these hearings, but as the gentlelady knows, this is a matter of great interest for not only Members of the Congress but the citizens of the city as well; and we appreciate your patience in waiting this long to present your testimony.

TESTIMONY OF DONNA BALLENGER, SPOUSE OF CONGRESSMAN CASS BALLENGER

Ms. BALLENGER. Thank you. I do not know exactly why I am here, other than the fact that I was a witness in April to a devastating accident at my home—right on the corner. Something—You, I trust, have read my statement which I do not care to go over again, but I have been sitting back there listening to an awful lot of people say an awful lot of things that have brought a lot of questions, and maybe I have more questions from you and the people that have already testified.

Well, let me say that the accident that I witnessed—The first people on the scene were neither the fire department nor the ambulance, and a Metrobus hit a taxi that was hit so hard the wheels were all under, and there was a very seriously injured passenger.

I found out later that it was called—I live on the corner where the power supply for the Hill is. There were three armed guards there all the time. They phoned in. This was not a layperson. The first person that ran to the taxi was a Capitol Hill policeman. This meant that there was two of them.

They were EMT trained. One is going for cardiac EMT. This has not even been addressed today, that the police were the first ones there. It was 5 or 10 minutes later, two fire trucks came up; and the firemen saw that the passenger was being administered to, and they just stayed and waited.

They subsequently left the scene, came back again. This is two fire trucks. This isn't three—came back, and their speaker was

right in my ear, and said, what do you mean, there's no emergency vehicle there yet? They immediately left again, came back on the other side of the accident, and this was over a long period of time.

They never do minister to the patient. It was always the two policemen. They never left, and they were in the taxi for over 50 minutes, both of them at the same time. The policeman—one of them called me the next day, and I said, well, why? Why didn't we get a better response than that? I am a hospital trustee. I've worked in an emergency department for 13 years as a volunteer. I'm very interested in the medical profession. And he said, well, I don't know why they didn't come; it was phoned in as a No. 1 priority, which was a head wound.

So the priority system evidently exists, but what good did it do? It was 55 minutes before the ambulance arrived.

The next question I have is, it wasn't a 911 call. It was phoned in by the fire department, the police department. These are professional people. They said that the injury—They had witnessed it. They are trained, and it still took 55 minutes.

The Mayor called me the next morning, because I had been on television as, I guess, a credible witness. When I called back, I spoke to a very nice gentleman in his office, and he said, well, Ms. Ballenger, it only took between 20 and 30 minutes. I said, I beg your pardon, I know how to read a watch, and it took 55 minutes.

They went back, and after a period of time came back and told me, there was a 52-minute response time. I'd like to know where the figures came from for computing this, if they thought it was 20 or 30 minutes one day, and it's 52 minutes the next day. This bothers me.

I didn't take much notice of the fact that you, of course, have to live in the District. I'm new this year—last year, really. If you need to know how to find places—The Mayor said that they got lost. I live three blocks from the Capitol of the United States of America and two blocks from this office building; and they took 55 minutes getting lost. I have a great problem with this.

Why do you have to live in the District? I can find my way around. I live in the District now, and I haven't been here very long. But the time differential from what their statistics said until I made them go back and redo their statistics bothered me, because how can you have a 7-minute response time when I had an hour for that one? It would have ruined their statistics.

Then I've heard a lot of horror stories since. I am just about finished, because I only witnessed one accident; but what I saw was horrifying.

[The prepared statement of Ms. Ballenger follows:]

Statement by Donna D. Ballenger before the Subcommittee on Fiscal Affairs and Health

August 5, 1987

On April 1st of this year, I was in my home at 450 New Jersey Avenue S.W. watching C-Span when I heard a thud that sounded like two cars colliding. I looked out of my window and saw no evidence of a collision and resumed watching the television. A very short time later, I heard a siren and looked out to see that a Metro bus had hit a taxi broadside on our corner. Immediately thereafter I heard and saw two fire engines pull up in front of my house and the firemen proceeded to the accident, and I saw two policemen in the back seat of the cab administering to the passenger. Very soon after this, a Metro car pulled up and a man proceeded to take pictures of the accident.

Since the accident took place immediately in front of the power plant for the Hill, which is guarded around the clock, I can only surmise that the quick response was to the call of the guards in the guardhouse. The speakers on the fire truck were loudly monitoring calls and the trucks left, only to return very soon to the same place.

Since some time had elapsed and no ambulance had arrived, I went to the corner to see what the holdup was. I probably have a greater than average interest in accidents since my husband set up the ambulance service in Catawba County, North Carolina, and I am a hospital trustee and volunteer. At this time I would like to quote a couple of statistics about the North Carolina service.

Catawba County covers approximately 400 square miles and has a 7 minute response time throughout the county. We are at present trying to make that even better by placing quick response units, consisting of Broncos with either EMT or Paramedics aboard, in areas not readily accessed. The present program has just received, for the second year in a row, the state award for service. It has also won the state award for CPR and/or heart saver plan. It also formulated a mass casualty plan that now covers the entire state.

As a crowd gathered at the accident scene in front of my home, a woman asked me how long the call for an ambulance had been in. I told her that the police had arrived over 25 minutes previously and she said to call Channel 4 since they were vitally interested in the poor response times. I did not want to do this since I was fairly new to the area, but she proceeded to call. The TV truck arrived within about 10 minutes and proceeded to do what TV reporters do. At this time the fire truck had departed again, but not before the speakers said loud and clear that they (the dispatchers) were upset that the ambulance had not arrived. (The next day, I received a phone call from one of the policemen who had helped the victim in the cab. He said that the injury hac been reported as a head wound which would make it a #1 priority.) Shortly, the fire trucks reappeared on the other side of the wreck.

Ballenger statement--page 2

At no time did I personally call 911 since the police were alerted immediately. However, everything leads me to believe that if I had been the one to call 911, it would have been two weeks before the arrival of help. Surely, the departments could respond quickly to official calls from their own vehicles. Also, there should be no question about the severity of the injury when called in by the administering agency.

I was asked to make a statement on TV and asked my husband if that would be all right with him, as I did not want to embarrass a Congressman. With his blessing, I did as requested and answered questions from the reporter.

I received a call the next day from Mayor Berry at my husband's office and returned it to speak to a very nice gentleman on his staff. He asked if I had any solutions and he was not pleased with my response that I felt the friction between the unions had a lot to do with the problem. Civil servants should be well paid, have liability insurance (which is only available here if paid for by the employee) and be able to reside outside the District. The housing costs are prohibitive in D.C. and the lack of training on the ambulances is appalling.

The total time of response for the ambulance for this accident was over 50 minutes. The "Golden Hour" for livesaving had elapsed by the time the poor patient reached a hospital.

Respectfully submitted,

Donna D. Ballenger

Donna D. Ballenger

Mr. FAUNTROY. Let me say, Ms. Ballenger, we certainly appreciate your coming forward, as you have, with a firsthand experience of what, obviously, was a horrendous delay in response to an obvious emergency, an emergency communicated by clearly professional persons, as you point out. Not only were the first persons on the scene Capitol Hill policemen who themselves had some competence to deal with the situation, that they in fact made the call to indicate the need for emergency service, but that also the fire department arrived and did not——

Ms. BALLENGER. Three times.

Mr. FAUNTROY. Three times, and that did not result in—so that's an amazing story, and I hope that—I only wish that someone from the District government were here now to explain to the committee and to me how in the world that could happen. But I am impressed as well with your own experience professionally in this area, and I wondered, on the basis of the experience in Hickory and in Catawba County whence you come, what you might feel we could learn from the experience there?

Ms. BALLENGER. You know, it's very different. We have to cover 400 square miles with a response time of 7 minutes, and it's going down because they're putting in miniunits with paramedics. Also, I'm wondering about—If they're going to have paramedics, which you really need—An EMT can't do an IV, and that's lifesaving. If you're sitting there not being able to get trauma victims under control quickly, the EMT thing is better than nothing but it isn't the answer. A paramedic should be quickly in the area or an advanced—We have an advanced EMT that can do IVs, which prepares the patient for any possible injections that they would need.

The way I see it, and I don't mean to be funny about it, but it looks to me like you ought to have a paramedic on your fire truck and your police car, because they got there. I don't mean to be flip, but they were on the scene administering. Also, the policeman that talked to me said he was paying for his own training, because he wanted to go into the cardiac EMT; and he said, also, Ms. Ballenger—he said, we have no liability insurance; and he said, you know, I don't know what I'm doing to my family. That was frightening.

When the one gentleman said there was a pool, he was saying for the fire department. Does that cover these other people also? I mean, maybe that's one of the problems. Are we protecting the people? I don't know. I can't answer that. My—After I keep getting these phone calls from people who work there, my question was, there was a lot—and I believe the doctor said it. There is friction.

It was the head of this department with the head of this union and there were like four unions and four heads of departments, and everybody was in complete upheaval, and nobody seemed to be in charge of this particular thing. I think that that's come out today.

I know fiscally—My husband is in politics. Fiscally, it is terribly difficult to come up with a very high price, say, head of this thing; but perhaps if there wasn't this great overlap of people in charge, that it might alleviate some of it.

I am not a professional other than what I know in Catawba County. We are dispatched by the police department. It's actually

the sheriff's department, because this is a whole countywide situation; and it is one desk with thousands of lights and five guys working it all the time. But their—If we can go cover a 400-square-mile—granted, not the traffic—and they are getting the response time—It is now below 7 minutes. There's something desperately wrong here.

There was no traffic—There was no traffic on the corner. They stopped it. There was no reason an ambulance didn't—As a matter of fact, an ambulance went by on an overpass, oh, probably halfway through this ordeal. I don't know where it was going, but this was a No. 1. Now you talk about priorities. I don't know if a layperson should do it, but these were professionals. It should have gotten something.

Mr. FAUNTROY. Well, your testimony has been very useful. I am fairly familiar with North Carolina. In Hickory, is it not true that they have a residency requirement for police and fire personnel?

Ms. BALLENGER. I don't know, but it's a lot cheaper than here.

Mr. FAUNTROY. Without question.

Ms. BALLENGER. I just bought a house or a mortgage.

Mr. FAUNTROY. Well, you have no quarrel there.

Ms. BALLENGER. I don't know. But this ambulance service is not city of Hickory. This is county. So we would have 400 square miles to live in, and you can really get some good, inexpensive housing out in the county.

Mr. FAUNTROY. Oh, yes. Well, thank you so very much for your testimony. I appreciate very much your patience in waiting this long to give it.

At this point, I'm going to recess the hearing until 2 o'clock, and in the process ask our remaining witnesses, particularly, Ms. Sperling, Mr. Haupt, Mr. Goldstein and Mr. Fishburne, together with Dr. Chen, Ms. Adams and Ms. Moreau, if they will kindly get a little lunch and come back, and understand that one benefit of having a nonvoting member chair this committee is that you're probably going to get on sooner than you would have, had we not continued the hearings while other members who represent less taxpayers than I went over to the floor to vote.

So we'll see you at 2 o'clock. Thank you.

[Recess.]

AFTERNOON SESSION

Mr. PARRIS. In the absence of the chairman, who is unavoidably detained for a moment, why don't we commence the hearing and begin the testimony of the balance of our witnesses.

The next panel is panel No. 2, Dr. Champion we, of course, heard from earlier; Dr. Chen, Ms. Adams and Ms. Moreau. And having said all of that, that's the two bells for another vote on the floor. So let us once again—I'll go vote very quickly and return as soon as possible. I apologize to all of you ladies and gentlemen for the inconvenience.

[Recess.]

Mr. FAUNTROY. The subcommittee will resume, and our next witness is Mr. Harry Teter who specializes in emergency medical issues. He represents several organizations in this field such as the

American Trauma Society, the Atlantic Emergency Medical Service Council, the National Study Center for Trauma, and the Emergency Medical Services, the National Association of State EMS Directors; and he has advised cities and States on EMS laws across the States. He has published a number of articles on EMS research, and we thought him to be a very valuable resource for us as we, as members, examine the emergency medical services issue here in our Nation's Capital. It's a very real pleasure to have you.

TESTIMONY OF HARRY TETER, ESQ.

Mr. TETER. Thank you very much, Mr. Congressman. It's a pleasure to be with you again. We worked 10 years ago or 9 years ago on the Voting Rights Commission, and I'm pleased to be with you on this issue.

Mr. FAUNTROY. Thank you.

Mr. TETER. Today, sir, I would like to draw your attention maybe into a broader look at the problem of emergency medical services. You have been focusing primarily on the 911 system, which is certainly appropriate, because it is a vital part of EMS. But what I would like to do is talk about the broader spectrum, and that is the whole delivery system of EMS, because though today we have 911 as an issue, indeed tomorrow it could be another aspect of the system to bubble up as a problem.

If we don't have a total coordinated system of EMS in the city, then we're never going to be able to truly get on top of the problems. As I said, when we look at emergency medical services, we have to look at several components of a system that EMS makes up. Those components can consist of our prehospital operation such as our transportation operations, our communications operations, our manpower that serves all of these, trained manpower for the EMTs, paramedics, et cetera; and then we have to look at the facilities and where we're taking victims.

We have to make certain that our facilities are in place and those that are capable of delivering trauma service are in line and a part of the system. All of these things are parts of the EMG system, and all are vitally important.

One of the things that I would like to draw your attention to today is the need to have a sounder emergency medical services law in the District of Columbia. Now why is that important? A law isn't going to make the system happen per se. A law can only define the system, set out the parameters of it, and give us a structure; but indeed I think that is the one thing that is lacking today in the District, and one thing that we can certainly do something about.

I have personally never been overly worried that we aren't going to be able to solve the immediate problem of EMS delivery in the 911 situation. If one looks at the District, you see some very fine components of EMS. You see some terrific medical facilities here in this town, second to none.

I guess it's kind of a dubious way to compliment them, but I happened to go to the George Washington Medical Center one time for an accident I was in. I could not have received better care. We have superb facilities.

We have excellent people that are involved in emergency medical services delivery in this town. I have the pleasure of working, really on almost a day-by-day basis, with the Atlantic EMS Council, with Ms. Mary Berkeley, who is the director of EMS; and I know her hard work in working to make the system come to fruition here. But what is lacking is the glue that makes all of the component parts of EMS come together.

That's where I think we can start by looking at a better law for the District of Columbia. I would hope that this committee would consider recommending to the D.C. Council that they consider a comprehensive emergency medical services law.

I think one of the important things that law must do is establish a central authority for EMS, because we have several components in the system. We sometimes have one part of the system being the responsibility of one party, and another part of the system being the responsibility of another party. That's difficult.

For the system to operate well, you must have strong central command. I would hope that when we look at this in the possibility of a new structuring of a new law that we would be able to create a stronger emergency medical services central force in Washington.

I think that such an operation would give us a greater degree of accountability. I would urge that when we do this and when we look at these—look at a new law, that we remember that EMS is really a medical issue. We're talking about a medical problem, which is trauma. I would urge that we look very strongly to the medical community to help in solidifying our system.

This present situation that we are facing and which we are dealing with—and I think everybody is working hard to restore confidence in the delivery system of EMS in this community—and this will be done. I have no doubt about it. But I think that in doing this, again, we should not just worry about the 911 issue per se. We should get that done, but we should look at the ability to have a whole system of EMS delivery in this entire city.

I am a resident of the District of Columbia. So I have a personal interest in this. When I dial 911, I want to be certain someone gets there. I want to be certain that person who treats me knows what they're doing, and I want to be certain that they are in touch with a facility where I'm going to be transported. These are all part of the system.

Again, as I say, I would urge that we look at putting a strong accountability and a strong force in an office of emergency medical services here in the District. I have looked at some 50 laws of the 50 States for emergency medical services, and I think that we presently have one of the weaker laws, but we can strengthen that.

It would worry me greatly if we didn't have the components out there, if we didn't have the good people and the good facilities that we have in the District. But they need this help, because one doesn't want to rely on personalities to make something work entirely. There's no getting around the fact that a strong personality is needed in almost anything to make it, I guess, advance quickly. But when one looks back, one wants to be certain that there is a framework there that doesn't require necessarily a personality, but it's a framework on which we build our system.

That's where I think we should look now and constructively build a better system, through a better law. This, I think, will ultimately help in the 911 issues or whatever issue will come down the pike; and there will be more. But it's a challenge, and I think, frankly, that the time right now, that we are going through, is an opportunity.

EMS has suddenly come to light here in the District, and we realize that this is a vital public service. This is, if you will, a third service that we have, police, fire and EMS. I think while it is a topic of great discussion, we should take the opportunity to make it a stronger system and to put something in place that will be lasting.

So I hope that this committee, and I hope that on your considerations that you will strongly consider an EMS law. I for one will be delighted to help in any way I can to bring it about.

[The prepared statement of Mr. Teter follows:]

STATEMENT OF HARRY TETER, JR. BEFORE THE SUBCOMMITTEE OF FISCAL AFFAIRS AND HEALTH OF THE HOUSE COMMITTE OF THE DISCTRICT OF COLUMBIA AUGUST 5, 1987

Mr. Chairman and Members of the Committee, My name is Harry Teter and I am appearing before you as Executive Director of the Atlantic EMS Council, (Atlantic EMS Council are the EMS Directors' of the District of Columbia, Maryland, Virginia, West Virginia, Delaware, Pennsylvania and New Jersey) Counsel for the Charles McC. Mathias National Study Center for Trauma and Emergency Medical Systems, and Counsel for the Maryland Institute for Emergency Medical Services Systems, the Atlantic Trauma Society and the National Association of State EMS Directors'. I have done extensive reviews and analyses of state emergency medical services laws in the state and I work continuously with Federal and state EMS legislative and administrative issues. I am particularly pleased to present my views regarding 911 and ambulance response within the more general context of EMS systems delivery.

Although I understand that today you are examining the 911 system here in the District of Columbia, I would nevertheless like to broaden your consideration to the entire emergency medical services system. One can't simply evaluate a rescue operation as an independent entity. 911 is not an end in itself, but rather a means of transforming a trauma victim into a patient receiving care at the most appropriate facility in a timely fashion. Today's focus on the effectiveness of the 911 emergency telephone system must be viewed from the proper perspective, namely as part of the EMS communications and transportation process. Indeed this process itself is merely a component of an overall system. In my judgement it is this concept of system which should pervade the Committee's deliberations today.

An effective EMS system has a wide variety of components, including properly trained personnel, efficient communications equipment, quick response transportation, and proper care facilities. Doctors, nurses, communications personnel, dispatchers, EMTs and paramedics must be highly trained specialists in emergency medicine. Additionally they must be effectively coordinated by a central medical command in order to maximize effectiveness.

Dedicated communications channels are esssential for minimal interference in the critical minutes of on-the-scene patient stabilization and subsequent transport. Again, dispatcher and 911 operators specifically trained in EMS, who are capable of receiving and relaying appropriate medical information, and who are directly under the sole control of a medical command must be employed. Only then can response times be shortened and the patient be stabilized and placed in a definitive care facility within the "Golden Hour."

Finally, the centerpiece of the EMS system, the trauma centers and hospital facilities, should be staffed with experts in trauma care and equipped with state of the art technology.

Citizens of the District of Columbia are fortunate in that they have some of the best trauma care facilities at their disposal. However, these facilities are only "parts" of a potential "whole" and can only treat patients as they receive them. If, because of some breakdown in communciations or transporation, the patient is delayed in reaching the trauma center, opportunities for minimizing the effects of the injury may be lost and the patient's recovery may be compromised.

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In my opinion, Mr. Chairman, the District of Columbia should strenghten its systems approach to EMS delivery by making the commitment to coordinate all the components under one central EMS authority. This authority alone must be fully accountable for all aspects of EMS from initial patient entry into the system (i.e., the first response) to exit. Since EMS is medical in character it should be subject to medical command in its entirety. This includes response to emergency calls on 911 and full control over transportation vehicles and personnel.

The best systems are those structured by strong state EMS statutęs. A significantly strenghtened EMS law in the District of Columbia would clearly delineate lines of authority and elevate the status of EMS by complete recognition of its atonomy. Such a concept is not novel. We have many models of successful EMS systems which can be examined and modified to fit the needs of the District of Columbia. Since 1973 when the Federal Government played an active role in establishing systems across this country almost every state have established some type of EMS law on which to build their system. The District presently needs to have a comprehensive law on which it too could build a strong medically centralized system. A law cannot guarantee a good system but without a law whatever system might be in place usually depends on individuals. This leads to personality clashes and a weak system. A good EMS law is the framework on which to hold a lasting system. It puts problems such as we are discussing today in a proper perspective and allows an objective analytical means to maintain and operate the system. I am familiar with all state EMS laws and would be happy to assist in any endeavor to strengthen the District statute.

In summary, the District has many of the components of a good system. The current crisis of confidence in 911 presents us with the opportunity to address the larger issue of systems while restoring public trust in our ambulance response times. In that light the problem of 911 can be resolved in a fashion which will complement all of the components and we will have established a comprehensive service for the citizens of the District which is truly greater than the sum of its parts.

Mr. FAUNTROY. I thank you, Mr. Teter, for your testimony. It is particularly meaningful in that it comes from one who is—has specialized in emergency medical issues, and it's for that reason that your testimony raises two questions which are of interest to me.

You may have noted that with each preceding I had raised the question, are there legislative measures that might be put in place to strengthen the delivery of emergency medical services in the District of Columbia; and I note that you have put a good bit of emphasis on that.

Do you think of any particular features of emergency medical legislation that apply that are in effect elsewhere in the country that might be a part of legislation here?

Mr. TETER. Yes, sir. I think several States have recently developed comprehensive EMS laws, and by that I mean that the law that would be created and established would create the good office, a strong office of emergency medical services. It would recognize it, I think, as a health issue. It would recognize the fact of accountability. It would recognize the fact that there must be a central command, if you will, of all of the components of the EMS. You must have one command. I would look to several States that have recently passed laws. Pennsylvania has a very fine new law in emergency medicine. Virginia has a very good law. California has a good law. We can bring a lot of these and say what we—and bring the strong parts to bear, so that we can create a better system, I think, here.

As I say, the law has to cover the components of EMS, has to decide who is in charge and then make certain that person is accountable. I think that is what is truly important.

Mr. FAUNTROY. Thank you. The second question which your testimony raises in my mind is whether those goals can be accomplished best through an emergency medical services department, or more specifically: Do you think that being a part of the fire department system here in the District of Columbia hampers or enhances the emergency medical services delivery?

Mr. TETER. Well, I think that it—possibly, in the best of all worlds, with no disparagement to any fire system whatsoever, that I would have the ultimate authority in an office of emergency medical services, because I think that's where it should be coordinated. But in any places the training must be done, and it's done very well, through the fire department. I just think the ultimate accountability, if you will, should be in an office of emergency medicine. I think that—because that office would be responsible for the entire system.

Again, the training and the EMT issues are only one aspect of that system, and it is the office of emergency medicine that would have to be responsible for pulling it all together. So because of that, even though no matter where they were trained, whether we have ultimately a third service created or whether we have it in the fire, the ultimate authority for seeing that it fits into the system and works well in the system should be in an office of emergency medicine.

Mr. FAUNTROY. Very good. Thank you. Mr. Parris, Mr. Teter is our witness.

Mr. PARRIS. Thank you, Mr. Chairman. I mean no disrespect of any kind to the witness, Mr. Chairman. The rules of the House and of the committee provide for receipt of 50 copies of the witness' testimony at least 24 hours in advance, if memory serves me. It's my understanding that this witness was invited to attend this hearing just on yesterday and that no copies of his statement has been received. I was not here when he made the statement. I don't have a copy of his testimony. So for those reasons, I regret that I have no questions.

Mr. TETER. Well, Mr. Congressman, it was a snafu in the mail that I did not get a notice that was sent to me, and I have asked that I be able to submit a statement; and I will do so within 48 hours. At anytime if you have any followup questions to me, I will be more than glad to answer them in writing.

Mr. PARRIS. I understood that, Mr. Teter. That's why I prefaced my remarks by suggesting that I mean that in no way disrespectful to you nor to the testimony that you presented to us. I'm sorry I was not here to hear that in person.

Mr. TETER. Thank you.

Mr. FAUNTROY. I thank you, Mr. Teter, not only for your contribution here but for your support over the years of full citizen's rights for District residents which you are one, and one of which we are proud.

Mr. TETER. Yes, sir. I want to vote. Thank you.

Mr. FAUNTROY. Thank you.

We do note as we move to the next panel of witnesses that we did have a problem getting testimony in advance of 24 hours for a number of witnesses. I'm going to excuse that on the basis of the fact that members—citizens have become unaccustomed in the past 12 years of bringing their primary concerns for local matters to the District of Columbia Committee which is as it should be; but as we've indicated, this is an issue in which the Congress is very much concerned, not only because it is the Nation's Capital but also because it's a national problem.

May I ask that Dr. Harry Chen, director of the EMS degree program at George Washington University Hospital will come forward, together with Ms. Sherry Adams and Ms. Margaret Moreau. So Ms. Adams and Dr. Chen, if you will comprise a—Oh, sorry. Ms. Moreau is here.

We appreciate likewise your statement. You may proceed now in the fashion which you choose.

TESTIMONY OF DR. HARRY CHEN, GEORGE WASHINGTON UNIVERSITY HOSPITAL, CHAIRMAN, MAYOR'S EMS TASK FORCE

Dr. CHEN. Mr. Chairman, Mr. Parris, I appreciate the opportunity to talk in front of you. I also apologize for not having a statement, although Mr. Parris has entered into the record the task force report which I feel in great length will reflect most of my comments at this time. I feel that my primary role here would be to answer any questions you had in regard to the task force report and in regards to where I see the EMS is headed at this time.

I do have a very short statement which I wish to make, and that is: More than 1 year ago a task group chaired by myself, appointed

by the Mayor's EMS advisory committee, submitted a report to that committee that identified serious problems with the District's system of prehospital medical care.

That report has been entered into the record by Mr. Parris. Concrete recommendations for positive change were made at that time. The task group report was subsequently approved by the whole EMS advisory committee and passed on to the city government for action.

Since that time, the city has formulated an action plan in response to that report. Implementation of the action plan has been the joint responsibility of the District of Columbia Fire Department, the commissioner of public health and the Mayor's office itself.

Despite the best efforts and good intentions of Mr. Downs and the commissioner of public health, implementation of the action plan has been a difficult task. While there has been definite movement toward improvement of the system, some members of the task group are concerned that it is too little, too late.

As such, prehospital care in the District of Columbia continues to have serious problems and continues to have the potential to deteriorate further. Good medical care does exist on the streets of the District of Columbia, but remains a haphazard occurrence due primarily to the valiant efforts of the providers on the street.

As medical providers in the District of Columbia, we continue to be generally concerned about the quality of medical care rendered on the streets, and submit that many of the problems identified in the original report continue to exist today. Further delay in implementation of the far-reaching changes necessary to improve the system potentially jeopardizes the health of the residents of and the visitors to our Nation's Capital.

Members of the committee, I submit that this is a critical time for emergency medical services in the District of Columbia. Now is the time for all of us to recognize our emergency and work together to improve the system. We all share a common goal, that to create a model EMS system for our Nation's Capital.

Mr. FAUNTROY. I thank you. We will go right to Ms. Adams and then to Ms. Moreau. Then we'll have questions.

Ms. ADAMS. I did not come prepared with a separate statement. We will operate as a group, as we usually do.

Mr. FAUNTROY. All right. Wonderful. Well, thank you so very much. We heard from Ms. Moreau as part of the panel with Dr. Champion. So let us proceed with questions.

You were here when Mr. Downs testified to the effect that some 137 recommendations from the advisory committee on emergency medical services are in the process of being implemented. You have just testified that, in your view, many of those—many of the recommendations have yet to be implemented. I wondered if you would care to give us a couple of examples of ones that you think are very important but which have yet to be implemented.

Dr. CHEN. I think one of the key problem areas identified in the task group report was that of medical control or medical oversight, what Dr. Champion referred to as quality assessment, quality assurance, what Mr. Teter referred to as the fact that this is a medical system and, therefore, needs medical oversight.

In addition, the whole EMS advisory committee has serious concerns about whether that is in fact the case at this time. The commissioner of public health has made a valiant attempt to fulfill this role in the interim until a new medical officer can be hired. I don't know whether they have gotten the information necessary for them to fulfill those responsibilities.

I think you might—As you can imagine, it's difficult for one city agency to get the information necessary to oversight another city agency; and I think it's a difficult task at best, and I do not know and I personally do not feel that they have been able to fulfill that responsibility.

That is one of the major areas of concern that I have.

Mr. FAUNTROY. Dr. Miller referenced comments on the daily review process that was outlined here. What is your assessment of the daily review process which Mr. Downs and the executive branch outlined to us today?

Dr. CHEN. Well, I think they do have those daily meetings. I have no doubt that they do. I'm concerned that to have such a meeting on that high a level really takes that medical supervision away from where it's needed the most, which is on the street itself; and to have high level city administrators meeting in an office is much, much different than to have that presence felt out there, so when Mr. Parris is out riding the ambulance that person wouldn't state to him that what the system needs the most is good medical control, somebody who cares, somebody who is knowledgeable, somebody who is committed to being there with them, beside them, if necessary.

I wonder if either Ms. Moreau or Ms. Adams has some other illustrations to give you.

Ms. MOREAU. We heard at the EMS advisory committee a month ago that there was dissension, as it were, between the fire department and the commissioner of public health, and that though they had these daily meetings, there really wasn't a passing of information back and forth freely among the two agencies. We understood that Mr. Yeldel became involved to try to interface between these agencies.

It just seems that this committee grows and grows and grows and grows, but the problems don't get solved. You have to understand, too, that a great deal of what we base our attention on now comes from the quality of patient care that we see delivered to the patients who arrive in our emergency rooms, our trauma centers, our involvement with the EMS advisory committee, and our involvement with the paramedic review board; because we have not actually looked at the system again.

After the task force report was delivered in July 1986, all of my lectures were canceled by the fire department, as well as the people from GW. We were no longer available to ride on the ambulances and then in essence sort of separated from the fire department. So a lot of what we see now comes directly from the providers, from the quality of care that they've been delivering, and from our work with the committees.

The other thing I think—another one of the issues that you see, that they spoke of this morning, was the training issue. We recommended a year ago that there be a very strong continuing educa-

tion process, that at the weekly sessions rather than giving people 3 hours of continuing education for simply having shown up, that they should be provided with a very detailed strong course so that they could maintain their skills.

As late as last week, they were still being given continuing education hours, and there was no speaker. When those kinds of little things are done, you can't be sure that the quality of care is being delivered that should be delivered to the citizens and visitors of this city, and it has caused us all a great deal of concern.

I'm not sure that we've come a long way in a year. I think we have seen some movement, but I don't think we've made a vast difference.

Ms. ADAMS. I think that I have to echo the opinions of the other members of this particular panel. In the years past Ms. Moreau and myself were intimately involved in what was going on as a community commitment of our respective institutions. Therefore, we rode not 20 hours but probably 20,000 hours in the past 10 years. We were intimately involved in the continuing education program. We were there in the middle of the night when problems arose of a medical nature, before they had a medical director.

All of those things ceased at the request of the fire department once we had participated in this task group report. So, again, we're looking at the things that the providers on the street see, and what we as medical providers in our emergency departments see. We're looking, yes, not at the larger issues but at the smaller issues possibly.

We recommended a year ago that the records for the training division be computerized with local printout capability, so that the director of the training academy for the ambulance bureau had within a reasonable amount of time the capability of knowing which of the EAB personnel needed recertification in what particular area. That's not been done. They are still trying to keep records on little blue index cards or in the central computer downtown where it may take a day or a week to get an appointment to get printouts on what goes on.

That was proved in the paramedic review board last month when people had to be suspended because their advanced cardiac life support certification had lapsed. These are the kind of things we are seeing. If we are seeing those little things, we have no reason to believe the other issues are being handled any better.

Mr. FAUNTROY. Thank you so much. My time has expired. Mr. Parris?

Mr. PARRIS. Thank you, Mr. Chairman. Let me basically indicate that I am very grateful to these ladies and gentlemen, not just for their appearance here today but for what I consider to be a quite constructive piece of fine work in the task force report that we've alluded to many times, and which has been entered into the record.

I especially am grateful to Ms. Adams, who is, as you may know, the wife of Rich Adams, the editorial editor of Channel 9, who is a friend of mine, for whom I have a high regard. Very nice to see you, Ms. Adams.

Let me just very quickly—the city—and we've heard this testimony. I think you ladies and gentlemen have been here most of the hearing, if not all of it. You've heard many times today that there's

a followup working group that's looking into the continued improvement of the situation here. Are any of you ladies and gentlemen on that working group?

Ms. MOREAU. No, sir.

Ms. ADAMS. No.

Mr. PARRIS. Were you invited to be?

Ms. MOREAU. No, sir.

Ms. ADAMS. No, sir.

Dr. CHEN. No.

Mr. PARRIS. Does it concern you that there is more study? I think—I've forgotten which—one of you ladies and gentlemen said that more study, more study—I think it was you, Ms. Moreau, but very little seems to be happening in the real world.

Ms. MOREAU. It's true.

Mr. PARRIS. Does the continued study and the inability to focus on the problems concern you?

Ms. MOREAU. Yes, it does; because I think that the citizens of the District are the ones that aren't getting ultimately what they deserve to have, the visitors and the citizens here. I think that it's got a lot of media coverage, and that tends to bring some of the issues up. It makes people defensive on one hand, and try to skirt the issues or get around the issues. The bottom line here is we're talking about people's lives. We are talking about whether somebody is going to get to the hospital in time. We're talking about whether someone is going to get on the scene in time to save a baby or to save a father or a mother, and it's difficult having spent my entire life working in medicine for the betterment of people and to help people get well to—it's difficult for me to understand why anyone, having seen the issues, having seen the relatively simple solutions to some of the problems, not to take action. I don't understand that concept.

I think—the other thing that really bothers me is I've almost reached a point of considering that we can't make a difference anymore; and I find that frightening.

Mr. PARRIS. Well, that's a fairly cynical attitude, Ms. Moreau.

Ms. MOREAU. Yes, it is.

Mr. PARRIS. I know you recognize that. I don't criticize you in any way for it. I regret that's the case. I would simply add that your point is perfectly well taken. We are talking in terms of serious concerns of public safety here. We're literally life and death.

I will give you an example. Former Congressman Widler yesterday in the cloakroom, chatting with me and others about some things—last night at 5 or 6 o'clock he dropped dead in another Member's office in this building. I don't know what happened in terms of the emergency services and the ambulance and all. That's not my point. The point is those kind of things happen constantly to human beings; and that's what this is all about.

So the point I'm trying to make is, if I understood Ms. Adams' statement, you ladies and gentlemen and others have in times past, from time to time, provided, I gather, on a volunteer basis some direct supervisory medical attention from trained medical persons of one capacity or another, and had done so for sometime. Is that correct?

Ms. MOREAU. Yes, sir.

Dr. CHEN. The whole task force report was totally voluntary.

Mr. PARRIS. Right. And you were involved, if you will, with the fire department in all of that in some professional way.

Ms. ADAMS. I think Dr. Champion probably said that very well. We've been doing it for 10 years. So what you are hearing when you hear Ms. Moreau say that isn't frustration of 10 minutes. We're talking 10, 12, 13 years when we volunteered personal time, when our institutions allowed us during normal business hours to be out riding medic units doing the legally required field evaluations on——

Mr. PARRIS. For medical supervision on the spot, so to speak. Is that correct?

Ms. ADAMS. Yes.

Mr. PARRIS. And then you wrote this task force—this report.

Ms. ADAMS. Yes.

Mr. PARRIS. And you were disinvited by the fire department to continue to be involved?

Dr. CHEN. That's a polite way to say it.

Mr. PARRIS. They didn't like your report. That's what you're telling us, isn't it? You somehow became persona non grata because you had the audacity to suggest that there was something less than perfection in the way they operated the system. Is that a fair statement?

Ms. MOREAU. Yes, sir.

Mr. PARRIS. That's what you're telling us?

Ms. ADAMS. I think that's a pretty accurate statement.

Mr. PARRIS. I suggest to you, Mr. Chairman, that situation, I regret. I think it's wrong, wrongheaded, shortsighted, et cetera; perhaps we can improve on some of those kinds of things.

Ms. MOREAU. Well, I want you to understand we're not complaining.

Mr. PARRIS. I understand.

Ms. MOREAU. We did the job we felt needed to be done, because we thought that it was going to make a difference, and we certainly all want to stay involved; because we have a vested interest in the system, and we have a vested interest in the people that come into this city and the people who live in this city. If we have to take the good with the bad, I guess we'll do that, too.

Mr. PARRIS. Well, I would refresh your memory, Ms. Moreau, on a statement I made earlier in this hearing, that I have been informed from people driving an ambulance, among others, that the biggest omission, if you will, of this entire system today, of all of its strengths and weaknesses, the biggest single omission is that there is nobody like you, that a relatively untrained, sincere but untrained and unqualified driver can go to and say, I got a guy laying here with X, what do I do about it.

Now that's the biggest omission in the whole system. Yet here's the agency of this city charged with the responsibility of operating this system who tell you to buzz off, because you say they're not doing it exactly the way they think they ought to. I find that astonishing.

Let me just ask a couple of more quick questions. The training of EMS personnel, fire personnel, particularly with regard to the CPR certification, EMT certification, first responder certification—you

have all stated in one way or another that the—those problems continue to exist.

Ms. ADAMS. Yes, they do.

Mr. PARRIS. Is it fair to say you have seen no real progress in those areas over the last year or 2 or 3? And if so, why not? And if not, what can we do about it?

Dr. Chen, Well, I have to just state one thing at the outset, and that is that we're more or less speaking from a position of ignorance in that before——

Mr. PARRIS. On current conditions.

Dr. CHEN. Current conditions. Before we wrote the task force——

Mr. PARRIS. But, Doctor, you all—Just to clarify the record here, you all, in one capacity or another, continue to be involved in the delivery of emergency medical service in this city——

Dr. CHEN. Yes.

Mr. PARRIS [continuing]. On a day-by-day basis. Ms. Adams is a member of the task force and assistant adjunct professor of emergency medicine. Dr. Chen, assistant professor of emergency medicine, director of George Washington's emergency medical degree program; and Ms. Moreau, education coordinator for the trauma center. I mean, you're not exactly cab drivers around here.

Dr. CHEN. That's true.

Mr. PARRIS. My question is, in the real world over the last 2 or 3 years or so, has there been dramatic refreshing improvement in, particularly, the areas of certification that I've alluded?

Dr. CHEN. All we can really speak from is the experience of the patients we receive, and I would say in the past 2 or 3 years I have not seen any improvement at all. If nothing—If anything else, I have probably seen a little deterioration.

Mr. PARRIS. So it might be mildly worse than it was when you wrote your report, which was——

Dr. CHEN. That was 1 year ago.

Mr. PARRIS. I understand—which I would characterize as constructively critical of the system as it then existed. Is that correct?

Dr. CHEN. That's correct.

Ms. ADAMS. It may be helpful to point out that the number of instructors available to train at the training academy has not increased appreciably. We recommended that they have—take advantage of the department of transportation standardized, formalized EMT training course, so that their instructors were certified and better trained to be familiar with national standards. That has not occurred.

The directorship of the EAB Training Academy itself has changed probably three, maybe four times, so that they don't have a stable directorship there either.

Mr. PARRIS. Would you ladies and gentlemen just—and this may be so broad as to not be helpful—but would you agree with the statement that, if there is—again, it's a question of judgment in terms of municipal services. But if there is one legitimate criticism of the system as you know it, it is that it has not received, in my opinion and, I hope, in yours, the kind of priority that it rightfully deserves in the administration of this city. Is that a fair categorization?

Mr. CHEN. I think that's a fair statement. I think you can even narrow that down. It hasn't received that kind of priority within the fire department. I think——

Mr. PARRIS. Within the fire department?

Dr. CHEN. Within the fire department itself. Obviously, the presence of Mr. Downs here and the commissioner of public health indicates that the Mayor himself does view it as a high priority, but within the fire department itself the support has not been there.

Mr. PARRIS. Well, if I might take one other shot at that, there has been some laudable messaging of the problem and some increased appreciation of the severity of the situation. I would give the city that. But I think the thrust of your testimony and others is that that might not have, to the extent that we would all like it to be, been implemented on the streets of this city in the real world with the medical problems of real people. Is that a fair summary?

Ms. ADAMS. I think that's a fair remark. We are still seeing things talked about in theory and not in practice. We feel like we need a massive amount of public education to teach people how to use 911, to teach people how to use 8DC-HELP. It's a year later. We haven't seen it.

How can you continue to complain about overuse of the system, abuse of the system, when you take no action to do something about it? That doesn't require a great deal of outlay.

Mr. Fauntroy has a great vehicle for educating people every Sunday. We have to utilize those kind of things.

Mr. PARRIS. You all are trained medical people in one capacity or another. Do you agree with the requirement—whether it's in the regulation or not, it's in the world, in this city. Do you agree with the requirement to transport everybody to a hospital facility of their choice, literally at anytime they ask for it? Does that make sense to you?

Dr. CHEN. I think, logically, it doesn't make sense; I think operationally and in the real world, when you have a system where one of the major criticisms is actual medical oversight, I don't think it would be responsible to allow that to occur until you were sure that the system was in place to monitor that activity. I don't think we have that confidence, or I don't have that confidence at this time.

Ms. MOREAU. It's the same kind of thing when you talk about priority dispatching. We have a system who only has five advanced support units, and you have to pick and choose when those units are going to be available. Then you need to ask the questions so that you can prioritize.

It's the same way in—with right to refuse. Arlington County's paramedics have the right to refuse transport. If a EMT or basic life support unit goes on the scene, they call for the paramedic. The paramedic examines that patient, discusses it with his medical control physician, and then says you don't need to go by ambulance. But we don't have that system here. We don't have anybody that has that much control and has that much accountability to let these guys go out and make those decisions. There is no oversight.

Mr. PARRIS. Let me share with you quickly an experience that I had at the time when I was in an emergency vehicle. We got a call, went to an address; where is not important. There was a gentle-

man there. I'm not a trained medical personnel of any kind, but I know people that have had too much to drink. Almost all of us have had that experience, to be around those kind of people at one time or another.

We asked the gentleman what his problem was. He said he was drinking too much, and he was. Now maybe it's just because I was there, but there was an emergency ambulance, an emergency medical facility—one of these reserve outfits that are just for that. There was a regular ambulance. There was a police car, all of us for this one drunk.

Ms. MOREAU. That wasn't just for you.

Mr. PARRIS. I regret that this gentleman had found that it was necessary to do what he was doing. My point is, they finally arrested him for public drunkenness. That happens, Mr. Chairman, in Virginia, just like it does in the District of Columbia. I give you that right now. OK?

They took this gentleman away in a police car. Had they not done so, we would have had to take him to the nearest hospital. Now I'm sorry, but you cannot, in my view, operate a quality emergency medical service system and haul every drunk up and down the streets of this city. It's just not possible.

Ms. MOREAU. No, the system is overwhelmed now and overtaxed; and there certainly does need to be some strong measures taken for abuse. But again, I think, from the medical standpoint, it's difficult for us to release those reins until we know that there is some control there and that there is some oversight. You can "what if" yourself to death.

Mr. PARRIS. And would you—Are you ready for the punchline? The driver of the vehicle, in which I was in, knew this guy, knew his name. They picked him up 15 times before in the last 6 weeks for the same reason.

Mr. FAUNTROY. Oh, my, my, my.

Mr. PARRIS. Mr. Chairman, let me just very quickly—the time is running on. Let me ask you ladies and gentlemen, if you could, give us three or four of the highest priority things that you would like to see implemented to improve this system. If you had your druthers today, what are four things you would do first?

Dr. CHEN. Well, I think one of my highest priorities would be to put into place an effective means of quality control, an effective means of monitoring the medical activities of the people out on the streets, of being there and having that medical presence on the streets to assure the medical community, to assure the city and the citizens that good care was being delivered. That would be probably my highest priority.

I think other high priorities are to put high level managers in, much as the city is intending to do, in position very high in the fire department or wherever to assure these are experienced people. They need to be experienced people in running emergency medical services. They need to have the support of the city, the support of the fire chief and the upper level management of the fire department. Those are really two of the higher priorities that I would have.

Ms. MOREAU. I think if I had to list four things, it would be a strong medical control officer. I would take it out of the fire depart-

ment. I would make it a third service, and a strong medical director; fix communications and the priority dispatching, educate them according to DOT standard and make sure that the job was done well by having the medical oversight for that area also. The last area would be training, the training in the physical—the medical oversight, so that we know we're meeting minimum standard, and we know that we're maintaining that standard. Those are the four issues I would have.

Ms. ADAMS. I think you could pick any one of those issues. I think I would go for medical quality assessment, medical quality assurance. I would be interested in upgrading the training. I would be interested and am very interested in doing something for those poor folks who are jockeying those ambulances out on the street.

It is fine to say we're not going to do away with the residency requirement but, by God, which one of you, on $23,000 a year, can buy a house in the District of Columbia? If you're going to make them live here, don't rob them of the "American dream" of owning your own home, being able to pay your bills. If you want them to live here, fine; but make it easy for them to do it. Make it possible. If deleting the residency requirement isn't done, there are other things that can be done to make this more attractive, to make it work.

They're working under a terrible amount of stress. It's a very difficult job to do in an ideal situation. You couple that with the fact that you can't make ends meet unless you work an enormous amount of overtime, you can't ever have the financial security or ability to buy a house—What's the average house payment here, $100,000, $117,000? Do you know a bank who's going to lend somebody who makes 23 grand a year base salary the money to buy a house?

You're asking them to work under a great deal of stress not only in their professional lives but in their personal lives. You're asking these people to give up homes, maybe to have to make the choice of giving up family. I'd want something done about that. They deserve something better.

In this country we ask an awful lot of the people who are risking their lives, and we don't give them much in return.

Mr. PARRIS. Well, I couldn't agree more with your just concluded comments, Ms. Adams. I made the very best argument I could. I wish I had made it as well as you just did. Now when we had that issue on the floor of the House just several weeks ago, month or so, I lost by 10 votes. Maybe next time we'll have a more enlightened decision on that subject.

Let me just add that the person who was driving the vehicle in which I rode, works 6 days a week, 12 hours a day every week in order to make enough money to live in this city. She does so because she is dedicated to the welfare of the persons that she takes to heart. I think that's almost criminal, and I wish and hope that we can persuade others in the Congress to see it that way one of these days.

With that, Mr. Chairman, let me conclude and ask unanimous consent to insert into the record a statement by Mr. Charles F. Englemann, executive committee of the American Ambulance Association, for the record.

Mr. FAUNTROY. Without objection.
Mr. PARRIS. Thank you.
[The prepared statement of Mr. Englemann follows:]

American
Ambulance
Association

A PRESENTATION TO THE

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON THE DISTRICT OF COLUMBIA

ON

AMBULANCE SERVICE WITHIN THE DISTRICT OF COLUMBIA

PRESENTED BY:

CHARLES F. ENGELMANN

MEMBER EXECUTIVE COMMITTEE

AMERICAN AMBULANCE ASSOCIATION

AAA Government and Public Relations
1800 K Street NW, Suite 1105, Washington, DC 20006
(202) 887-5144

Dear Chairman, Members of the Committee:

I am Charles Engelmann, a member of the Executive Board of the American Ambulance Association, which is the largest Association of private ambulance providers in the country. I am also President and Chief Executive Officer of Advance Ambulance and Oxygen Service, Inc. which is based in Chicago, and provides services throughout the entire Chicago Metropolitan area. I appreciate and welcome this opportunity to share my thoughts with respect to the current ambulance crisis within the District of Columbia on behalf of the American Ambulance Association.

During recent months, there has been considerable media coverage concerning the District's Emergency Medical Service system. As providers of emergency medical services, this coverage has been of particular interest to the American Ambulance Association. The problems identified are not germane strictly to the District, but are ones that have been encountered in similar municipalities throughout the country. The primary problem areas encompass response time performance, manpower and quality assurance.

One solution which can be unilaterally applied to both quality assurance and enhanced response time performance is the system of staffing and equipping all ambulances at the paramedic level. An example of where this system has proven most effective is Syracuse, New York. Having only the paramedic level of ambulances eliminates the time consuming and liability incurring process of dispatch screening to determine what level of ambulance may be required. It also enhances response time performance in that all of the system's ambulances are staffed and equipped to handle the most serious emergency situations.

Another method utilized to enhance response time performance is through the development of a centralized dispatch center through which all requests for services and actual unit deployments are handled. In Fort Worth, Texas, for example, a dispatch center is equipped to a state of the art level of sophistication utilizing an enhanced 911 system, computer-aided dispatch and an electronic ambulance tracking system. This system has enabled the ambulance provider to achieve an impressive response time performance of 92% of all Priority 1 calls in under eight minutes, reflecting a 30% improvement over the previous system.

A primary asset in quality assurance is the development and maintenance of an independent medical authority comprised of physicians, qualified nurses and paramedics. It is the responsibility of the authority to establish and maintain ambulance protocols and treatment modalities that are reviewed on a regular basis. In Fort Wayne, Indiana, such an authority has been established which reviews the performance of field paramedics on a monthly basis. This program has been proven effective as demonstrated by the high quality of patient care its citizens receive.

The development and maintenance of the first responder program is another method which is employed in many communities to ensure that all emergency patients are seen within minutes. In the Chicago metropolitan area, first responder programs utilizing fire, police or volunteer personnel trained at the EMT level has proven most effective.

In Tulsa, Oklahoma, the EMS program has been able to achieve an almost unparalleled response time performance level through the utilization of a system status management program. Such a program required the provider to perform ongoing evaluation of call volume by both the hour of the day, day of the week and call location, the analysis of which determines the number of ambulances required to service the community at any given hour on any given day. The outcome has been the development of an ingenious scheduling system which allows the system to be both cost effective as well as efficient in enhancing response time performance.

The location data of the calls allows the dispatch center to determine where available ambulances should be stationed. Other factors taken into consideration include traffic flow patterns (i.e., rush hour situations) which may alter an ambulance's response capability drastically.

In review of the above, it is not coincidental that all of the areas discussed are currently serviced by private ambulance providers. The contracting process in many of these communities protects the community in the event of inadequate performance or default of a contractor through the establishment of three-way lease agreements and performance bond forfeitures. It additionally rewards the contractor for providing a cost effective quality assured emergency medical systems program.

In closing, I refer to an Office of Management and Budget Directive (OMB Circular 76) indicating that agencies of government should contract with the private sector whenever possible. Doing so will result in increased productivity and lower total cost of providing services. We therefore recommend that the District consider privatization as the most advantageous and viable solution to its ambulance crisis.

Again, Mr. Chairman, Members of the Committee, I thank you for this opportuunity and privilege to express the concerns of the American Ambulance Association to you today.

Mr. FAUNTROY. We'll move next to the final panel which will include Ms. Sharon Sperling, union representative of the Communications Workers Local 2336, D.C. Ambulance Dispatchers; Mr. Calvin Haupt, the AFGE Local 3721, committee researching health problems; Mr. Jeff Goldstein, a member of AFGE Local 3721; and Mr. Frank M. Fishburne, president of AFGE Local 3721.

We have Mr. Fishburne's testimony, and I recognize that Mr. Goldstein, Mr. Haupt and Ms. Sperling were unable to give us advance testimony; but you may proceed.

Ms. SPERLING. You have mine.

Mr. FAUNTROY. Oh, yes, we have yours. Would you want to lead off, Ms. Sperling, please.

TESTIMONY OF SHARON SPERLING, CWA LOCAL 2336, AMBULANCE DISPATCHER

Ms. SPERLING. The only thing that I'd like to bring out is the—communications being the core of the fire department emergency ambulance bureau, we need good working equipment which we don't have right now. We need another channel, at least one more, preferably three or four channels for the emergency ambulance bureau.

All of their radio traffic is on one channel without—and we need training. We don't get any training. Without those things, communications is going to die and, therefore, the fire department and emergency ambulance bureau; because if we can't perform our job, then they can't be expected to perform theirs.

Mr. FAUNTROY. Thank you. Now we'll query each of you following the general presentation.

[Ms. Sperling's statement, with attachments, follows:]

TESTIMONY OF MS. SHARON SPERLING
CWA LOCAL 2336
D.C. AMBULANCE DISPATCHER

Emergency crisis as defined in the 1980 edition of the Random House College Dictionary, is a situation demanding immediate action. A crisis is a vital or decisive turning pointin a condition or state of affairs, and everything depends on the outcome of it. Right now the District of Columbia Fire Departmentis in an emergency crisis due to the inaction, complacent and indecisive attitude of our District Government Leaders and Fire Department Officals. The District of Columbia Fire Department Communications Division is the core, the most essential part of the Department. However, the core is in a state of decomposition due to this complacency, indecisiveness and inaction. Until the City Leaders and the Fire Department hierarchy make a concerted effort to correct and resolve this inefficiency, the discrepancies, morale and the racial and sexual tension, the Communications Division will continue to decay. Ergo the Fire Department will decay.

When the computer was purchased 10 years ago it was outdated and now with the current technology available it has become obsolete. With the growing number of incidents generated by the District Fire Department and the Emergency Ambulance Bureau the computer has become completely inadequate.

It is my belief that until the powers that be in the District Government and the Fire Department come to grips with the uniform force versus the civilian force the Fire Department will continue to stagnate. The uniformed civilians of the Fire Department are treated worse than "Bastard Step-Children". They are caught in a gray area between the Fire Department Rules and Regulations and the District Government Employee Regulations.

The Fire Department's Communications Division is comprised of 47 uniformed civilians and these persons are responsible for all fire and medical emergencies. These fire and medical emergencies began, for the dispatcher, at the moment the telephone is answered and continue until the last unit is placed in service. We as dispatchers have, in the last 10 months handled approximately 54,000 fire incidents and 100,000 ambulance incidents and this with 2 months left to go in the fiscal year of 1987! In fiscal 1986 we handled 54,441 fire incidents and 103,655 ambulance incidents. When I use the term incident I don't refer to the number of apparatus units but to separate calls for emergency service. We as dispatchers are asked to achieve this responsibility with malfunctioning equipment and in some instances no equipment. But due to the dedicated hard-working dispatching force we get the job done in the most expedient and professional maner possible.

On the 20th of December 1986 the uniformed force of the Emergency Ambulance Bureau received an increase of $2,248 giving them a starting salary of $19,117 for a starting grade of DS-6. The dispatchers on the other hand were not given the benefit of this salary increase and our starting salary remains $16,869 for a DS-6. The District Government and the Fire Department felt the medical personnel deserved a monetary increase and indeed they do. An ambulance person might handle anywhere from 12 to 24 incidents per 12 hour tour of duty, the record being 24 incidents with 18 transports to area hospitals. However, the dispatchers handle 300 or more calls which turn into incidents per 12 hour tour of duty. As dispatchers we are entitled to 2 fifteen minute breaks and one half hour lunch break per 12 hour tour of duty. Only more times than not we are too busy to take these breaks and our lunch is eaten when we can, usually between calls if we are able to get up to get our lunch in the first place.

Another factor that the District Government nor the Fire Department has considered; and if they have, they have chosen to look the other way, is the stress factor as well as the noise level of the room in which we work, and thier effect on the health of the employees of the Communications Division. When we bring up the problem of stress to management we are told that there is no stress that we, the dispatchers, create the stress. The stress comes every time the telephone rings and we answer because we hold someone's life and/or property in our hands. If we make a mistake someone could die and/or lose all of thier possessions. Another factor that may, and has in a lot of instances caused stress, is the media coverage that has placed us under a microscope with no managerial support or backing. It seems to me that the City Government and the Fire Department want to go back to the 18th century when they had watch towers.

The supervisors of the Communications Division have gone from supervising a maxium of 6 persons to supervising 12 to 14 persons per tour. The captain of a fire company only supervises at the most 10 to 12 persons. The biggest difference is the salary and the training that they receive as opposed to that of the Communication Supervisor. The differences between the fire captain and a supervisor in the Communications Division is almost mind-boggling. Another difference being the fire captain is only responsible to his Battalion Fire Chief where as the Communications Supervisor is responsible to the Fire Department as well as the Mayor's Command Center and any other agency that the Fire Department and the Mayor's Command Center deem necessary. Recently the hierarchy of the Fire Department and the District Government Leaders have deemed it necessary to place 4 fire lieutenants in the Communications Division to supervise the supervisors who are supervising the dispatchers. These lieutenants have no knowledge of the work and have received no training about the inner working of the Division. I feel that thier services can best be served by placing them back in the fire-fighting division, and then completely restructuring the Communications Division by adding two additional assistant supervisors per-crew to take care of the immediate supervision of the ambulance board and the fire board. As well as helping morale by improving our career ladder. This would free the senior supervisor so that he could do the enormous amount of paper work that goes with the day-to-day operation as well as the emergency notifications and the overall supervision of the operations floor.

Of all the problems in the Communications Division, training is the worst in that it is almost non-existant. The City recently hired 15 new employees and after 1 week of riding fire and medical apparatus and 1 week of a class room setting introducing the new hires to the fire service, they were assigned to the various crews. Upon thier arrival these 15 persons were assigned to senior dispatchers for the more formal training. This training consists of a senior dispatcher trying to teach a person with no prior dispatching experience how to answer emergency calls and to operate the emergency equipment while also carrying thier full work load. If it is extremely busy that day the trainees get no training that day and they sit for 12 hours with nothing to do except become confused from all of the goings on. The end result being more stress to the senior dispatchers and, if you are lucky, a trainee who can hang in there long enough to learn enough about emergency dispatching to become a fairly competant dispatcher.

Attached are supporting charts taken from the June 1987 Edition of Firehouse Magazine showing the District of Columbia's Fire Department ranking as opposed to other major cities across the nation. The District with a resident population of 626,900 and a daytime population of 965,200 ranks 4th in the nation after New York, Chicago and Los Angeles City whose daytime population alone is in the millions. This factor alone increases our work load and responsibilities. Other supporting data taken from the fiscal year 1986 Annual Report as well as Fire Department Memoranda.

MEMO: Wish List for a New CAD System.

To: Chief Hampton

From: Detailed Don Date: 2/21/87

The C.A.D.(Computer Aided Dispatching) system we've learned to love has its short commings. The enhancements we would like to see would only be possible with a modern, more powerful computer.

The computer would have to have some provisions for hardware reliability ("fault tolerance" would be ideal) for our needs. Also, the operating system designed for transactions processing would be perfectly suited to our mission. The following are enhancements (hardware and software) which would put our system in the front of CAD systems across the country:

- the software should interface with C&P's E911 system to minimize keystrokes.

- the A.V.L. system should be enhanced so that the engine companies can be displayed with change of color for change of status, along with location changes of the ambulances. CAD could show closest Amb's at time of dispatch.

- the data base should provide the dispatcher with data in the surrounding area, as well as specific data to that address; i.e., street closings, hydrants out, etc; as well as invalids, S.I.D.S. babies, A.I.D.S. patients, etc.

- the data base should minimize the modification effort when an engine company changes location. (E12 move)

- the system will need to be modified sooner or later, and to accomplish this the software source code must be provided so our own in-house changes can be made.

- the Communication Division needs its own programmer/analyst because, with any computer system this complex, someone needs to be on hand.

- the storage devices and software should be available to store at least 3 months of incidents and access

- the dispatch should format a message and send it to the house of each responding unit. This should be received on a station printer attached to a Personal Computer which will be available to the house Capt. for various in-house uses.

- the system should utilize mobile data terminals (MDT) to communicate with the units "on the run." Could provide all special conditions (PCB's, etc), hydrant locations, etc.

- the system should be equipped with word processing capabilities for the use of office personnel.

- messages should be easily sent between dispatchers (to cut down on the need to yell across the room), stations, etc.(Electronic Mail)

- the system should be able to allow splitting of 2-unit companies.

D.C.-44
APRIL 1980

Memorandum ● Government of the District of Columbia

TO: DFC Archer

Department, Agency, Office: F.D.

FROM: Don Williams, Detailed CAD Consultant

Date: 2/5/87

SUBJECT: Brief overview of CAD

The D.C. Fire Department's Computer Aided Dispatch system consists of two Data General Corporation, Eclipse S/200 computers with 256K bytes of memory. The operating system is RDOS (Real Time Disk Operating System). One Eclipse is used to backup the other; and it is used for off-line testing and developement, and log reporting.

Each system is outfitted with an 800 bpi magnetic tape drive and a 300 line per minute printer. The tape logs all closed incidents and the printer logs all activity from each terminal position. The terminals are manufactured by Ann Arbor Terminals; they are ANSI-standard and are capable of displaying thirty lines of data with another scrollable thirty lines of data within its own memory. They also have the capability of two protected areas of varying size (upper and lower).

The on-line system controls nine terminal positions with differing capabilities (4 ambulance, two fire, two fire radio, and one supervisor position). Each terminal has twenty-one function keys for dispatching and reviewing status changes. One function key is a 'Menu' key with an additional fifteen low priority functions.

Washington, D.C.
"A Capital City"
Protected
By
The No. 1 Fire Department
In Our Nation

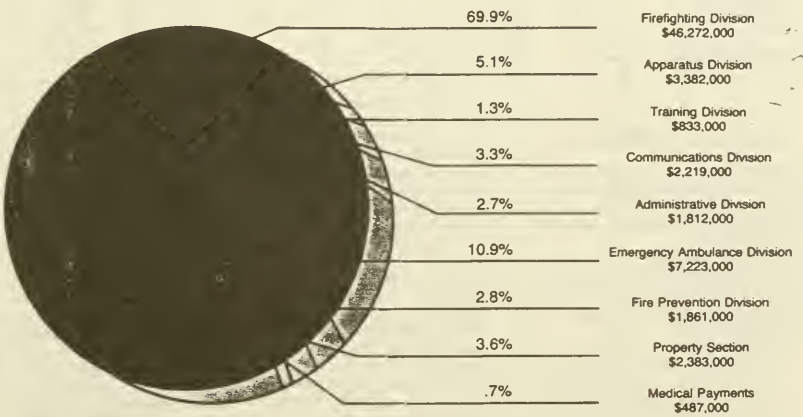
Population	626,900
Daytime Population	965,200
Average Visitors Per Day	62,191
Area	69.7 sq. mi.
Area Occupied By Fed. Govt.	19.8 sq. mi.
Property Tax Base	164,967
Assessable Tax Base	155,748

DISTRICT OF COLUMBIA
Fiscal Year 1986 General Fund Operating Budget

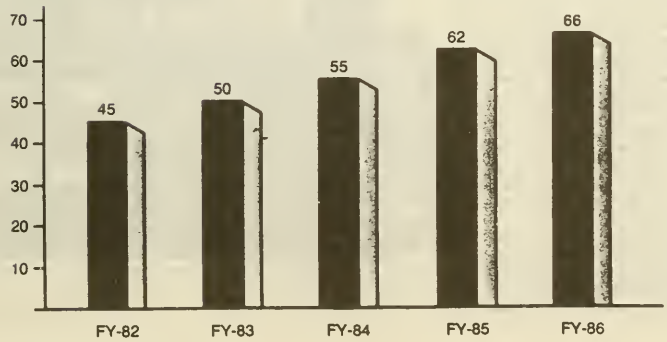
$2,319,088,000

D.C. Fire Department's
Operating Allocation
2.9%
$66,472,000

D.C. Fire Department's Operating Budget
Fiscal Year 1986



D.C. Fire Department Operating Budget



FIRE DEPARTMENT APPARATUS

78 Pumps
22 Aerial/Ladder Trucks
6 Rescue Squad Trucks
31 Ambulances
41 Sedans/Station Wagons

APPARATUS DIVISION EXPENDITURES

New Apparatus	$1,625,000
New Breathing Apparatus	$ 172,500
Hose	$ 65,000
FIREFIGHTING EQUIPMENT	
Tools & Appliances	$ 60,700

FIRE AND MEDICAL ALARMS DISPATCHED BY THE COMMUNICATIONS DIVISION

	Initial Alarm	Additional Alarm	Multiple Alarm	False Alarm	Medical Alarm	Ambulance Alarm	Total Dispatch Activity
October	1,860	45	1	126	2,116	8,296	12,318
November	1,736	55	3	89	1,905	8,204	11,903
December	2,346	50	3	98	2,028	8,234	12,661
January	2,147	41	3	106	1,917	7,953	12,061
February	1,814	32	1	107	1,899	7,332	11,078
March	2,154	58	5	94	2,507	8,202	12,926
April	2,144	42	2	151	2,375	8,391	12,954
May	2,270	48	2	116	2,477	8,844	13,641
June	2,503	45	1	112	2,582	8,869	14,000
July	2,410	32	3	103	2,947	10,575	15,967
August	2,108	31	1	120	2,634	8,925	13,699
September	2,091	39	1	122	2,741	8,832	13,704
Total FY 86	**25,583**	**518**	**26**	**1,344**	**28,128**	**102,657**	**156,912**

Communications Division

Through three separate radio systems, and by using Computer Aided Dispatch, all fire and rescue units are directed by the Communications Division to respond throughout the city.

In addition, the Division installs, repairs and maintains all base, mobile and portable radios assigned to the Fire Department. In fiscal year 1986, the division was responsible for:

- "Enhanced 911" emergency telephone system. When an emergency call is placed in the 911 system, it is routed through the C&P Telephone Company computer prior to coming to the Communications Division. When Operations answers a call, the caller's phone number and address appear on a small CRT screen. This tool allows the Fire Department to verify an address and identify persons reporting false alarms. Another feature of the 911 system allows the Communications Division to serve as the back-up Public Safety Answering Point (PSAP) in the event an unforeseen incident should happen at Police Headquarters. (If Police Headquarters must be evacuated, all 911 lines for police, fire and ambulance would be answered at the Communications Division.)
- Life Safety System Alarm Console. This system gives the elderly and the handicapped a means to summon fire and/or medical assistance at the touch of a button. The console allows the Communications Division to keep a daily check on those who have the Life Safety System. The unit will transmit an alarm if it is not reset every 24 hours. When this alarm sounds, a telephone call is made to the person, and if no answer is received, a Fire Department unit is sent to check on his or her well-being.
- Priority dispatching for the Emergency Ambulance Division went into effect during FY'86. Through the system, a call-taker prioritizes calls for medical assistance, and the medic, ambulance, fire and rescue units are dispatched within a time sequence according to their assigned priority.
- The new Local and Box Alarm areas and assignments for Engine Company No. 33, 1st and Atlantic Streets S.E., have been prepared and are ready for service.

Preparations are being made to install 800 MHz radio systems and automatic vehicle locators in ambulance and medic units. This will be a great improvement over the single frequency now used for the ambulance service, and will allow dispatchers to locate and deploy the ambulance or medic unit that is closest to a medical emergency. Computers are being studied and evaluated to replace the present one on which the Computer Aided Dispatch System operates, and negotiations are under way to replace the 11-year-old Dimension telephone system.

District of Columbia Fire Department Firefighting Responses

Engine Company Responses

* Initial alarm = street, local or box ** Additional = Special, task force, transfer, water supply

Engine Companies	* Initial Alarm Responses	** Additional Alarm Responses	Multiple Alarm Responses	Total Fire Alarm Responses	Medical Alarm Responses	Total Responses	False Alarm Responses	% Medical Responses	Rank By # Of Responses
E-1	2,005	20	6	2,031	574	2,605	66	22	6
E-2	1,227	40	3	1,270	570	1,840	40	31	20
E-3	937	90	6	1,033	563	1,596	44	35	22
E-4	1,269	51	7	1,327	997	2,324	64	43	11
E-5	808	31	1	840	340	1,180	15	29	28
E-6	1,153	36	7	1,196	938	2,134	110	44	14
E-7	816	72	6	894	593	1,487	40	40	24
E-8	1,070	54	5	1,129	89	1,818	64	38	21
E-9	1,478	49	6	1,533	1,197	2,730	44	44	5
E-10	1,359	47	1	1,407	2,148	3,555	206	60	1
E-11	1,197	12	4	1,213	963	2,176	88	44	12
E-12	1,152	59	9	1,220	1,151	2,371	119	49	9
E-13	918	27	5	950	340	1,290	340	26	27
E-14	855	19	1	875	509	1,384	77	37	26
E-15	1,324	27	3	1,354	985	2,339	94	42	10
E-16	2,032	41	7	2,080	1,378	3,458	56	40	2
E-17	788	29	3	820	569	1,389	44	41	25
E-18	1,350	71	7	1,428	730	2,158	112	34	13
E-19	1,226	28	1	1,255	684	1,939	53	35	19
E-20	693	3	1	697	447	1,144	15	39	29
E-21	946	23	4	973	544	1,517	27	36	23
E-22	882	3	1	886	1,205	2,091	59	58	15
E-23	1,362	28	4	1,394	556	1,950	34	29	17
E-24	1,042	29	4	1,075	871	1,946	83	45	18
E-25	1,722	0	0	1,722	1,580	3,302	144	48	3
E-26	895	32	4	931	1,038	1,969	49	53	16
E-27	1,347	25	0	1,372	1,192	2,564	104	46	8
E-28	518	81	9	608	318	926	10	34	31
E-29	447	7	2	456	96	552	8	17	32
E-30	1,162	1	0	1,163	1,642	2,805	112	59	4
E-31	534	1	3	538	414	952	0	43	30
E-32	1,465	13	1	1,479	1,101	2,580	105	43	7
Total FY'86	35,979	1,049	121	37,149	26,922	64,071	2,426	42%	

Rescue Squad Co. Responses

RS-1	1,756	85	0	1,841	238	2,079	25	11	
RS-2	1,330	78	0	1,408	106	1,514	23	7	
RS-3	1,097	98	0	1,195	395	1,590	25	25	
RS-4	541	30	0	571	63	634	3	10	
Total FY'86	4,724	291	0	5,015	802	5,817	76	14%	

Truck Company Responses

* Initial alarm = street, local or box ** Additional = Special, task force, transfer, water supply

Truck Companies	* Initial Alarm Responses	** Additional Alarm Responses	Multiple Alarm Responses	Total Fire Alarm Responses	Medical Alarm Responses	Total Responses	False Alarm Responses	% Medical Responses	Ranking By # Of Responses
T-1	788	20	3	811	9	820	7	1	10
T-2	1,366	33	6	1,405	7	1,412	30	0	3
T-3	1,387	84	7	1,478	18	1,496	25	1	1
T-4	906	125	11	1,042	15	1,057	39	1	8
T-5	584	25	2	611	0	611	16	0	15
T-6	1,221	33	1	1,255	12	1,267	39	1	4
T-7	1,039	131	4	1,174	12	1,186	61	1	7
T-8	1,389	2	1	1,392	49	1,441	56	3	2
T-9	1162	54	7	1,223	18	1,241	17	1	5
T-10	631	34	0	665	6	671	8	1	14
T-11	749	2	3	754	14	768	33	2	13
T-12	535	2	1	538	5	543	11	1	17
T-13	872	108	1	981	72	1053	16	7	9
T-14	421	119	8	548	10	558	1	2	16
T-15	730	21	1	752	24	776	17	3	12
T-16	1,137	62	1	1,200	21	1,221	22	2	6
T-17	745	4	0	749	32	781	57	4	11
Total FY'86	15,662	859	57	16,578	324	16,902	455	2%	

Battalion Fire Chief Responses

BFC-1	1,208	27	7	1,242	0	1,242	86	0	4
BFC-2	1,633	13	2	1,648	0	1,648	37	0	2
BFC-3	1,188	14	2	1,204	0	1,204	26	0	5
BFC-4	1,536	15	1	1,552	0	1,552	105	0	3
BFC-5	669	16	5	690	0	690	9	0	7
BFC-6	1,775	27	4	1,806	0	1,806	55	0	1
BFC-7	957	17	5	979	0	979	106	0	6
BFC-8	610	9	0	619	0	619	98	0	8
DFC	415	21	3	439	0	439	0	0	0
Total FY'86	9,991	159	29	10,179	0	10,179	522	0	

Special Unit Responses

* Salvage and Compressed Air Truck

Foam Units	281	17	3	301	0	301	0	0
Metro	14	63	0	77	0	77	0	0
* SCAT	8	184	19	211	0	211	0	0
Light	0	16	0	16	0	16	0	0
HAZ MAT	137	56	0	193	0	193	0	0
Rough Rider	1	0	0	1	0	1	0	0
Fire Boat	127	3	0	130	20	150	3	0
Total FY'86	568	339	22	929	20	949	3	0

UNIT	LOCATION	Ward	FY'85 Responses	FY'85 Transports	FY'86 Responses	FY'86 Transports
ADVANCE LIFE SUPPORT (Paramedic) UNITS						
Medic 1*	3420 14th St., N.W.	1	5,736	2,057	6,711	2,313
Medic 3	2425 Irving St., S.E.	3	5,114	2,197	5,941	2,426
Medic 9	1520 C St., S.E.	6	5,629	2,726	6,685	2,662
Medic 11	2225 M St., N.W.	2	5,390	2,167	6,332	2,355
Medic 18*	4801 North Capitol St., N.E.	4	4,879	1,945	5,708	2,283
BASIC LIFE SUPPORT UNITS						
Ambulance 2	1763 Lanier Pl., N.W.	1	6,413	3,728	6,894	3,688
Ambulance 4	4801 North Capitol St., N.E.	4	6,027	3,046	6,027	3,681
Ambulance 5	1300 New Jersey Ave., N.W.	2	6,365	4,035	6,454	4,000
Ambulance 6	450 6th St., S.W.	2	5,205	3,253	5,690	3,493
Ambulance 7	500 F Street, N.W.	2	5,899	3,520	5,925	3,564
Ambulance 8	4300 Wisconsin Ave., N.W.	3	4,747	2,335	4,537	2,247
Ambulance 10	50 49th St., N.E.	7	6,111	3,453	6,188	3,724
Ambulance 12*	2813 Pennsylvania Ave., S.E.	7	6,265	4,237	7,085	4,665
Ambulance 13	2425 Irving St., S.E.	8	6,663	4,347	7,424	4,252
Ambulance 14	1018 13th St., N.W.	2	6,355	3,776	6,870	3,797
Ambulance 15	439 New Jersey Ave., N.W.	2	5,906	3,595	6,307	4,084
Ambulance 16	1520 C St., S.E.	6	6,718	4,623	7,217	4,441
Ambulance 17	1626 North Capitol St., N.W.	5	6,875	4,826	7,457	4,585
Ambulance 19*	2531 Sherman Ave., N.W.	1	6,545	4,466	7,031	4,119
Ambulance 20*	4930 Connecticut Ave., N.W.	3			1,996	1,056
	TOTALS		112,842	64,332	124,479	67,435

* Denotes new or relocated units.
Note: Ambulance 20 in service from 4/1/86

Safety Office

The Safety Office has responsibility for overseeing all aspects of personnel safety, including: apparatus design, new equipment, uniforms and protective clothing, vehicle safety, training, physical fitness, and virtually every aspect of the work environment.

Injuries

Fire Emergencies	395
Non-fire Emergencies	47
Training	24
Fire Station	115
Responding and Returning	79
Recurring	32
Other	42
Total	734

Firefighting Division

The Firefighting Division comprises 54 firefighting companies strategically situated throughout the city.

These companies are grouped into eight administrative districts (battalions), with each battalion platoon group commanded by a Battalion Fire Chief. The entire Division is commanded by the three Deputy Chiefs, each assigned to one of the three platoons.

The Department provides fire protection services for the White House, the Capitol, the House and Senate Office Buildings, and all embassies. Protection is also provided for the heliport at the White House and the landing pads on the Ellipse, the Mall, and at the Vice President's residence at the Naval Observatory.

Each engine company houses two pieces of pumping apparatus: one hose wagon and one pumper. There are 64 front line pumpers in service. Each engine company and each truck company has a minimum of four firefighters and one officer per shift.

All truck companies, with the exception of two, are tractor-trailer types with a permanently mounted metal extension ladder with 100 ft. maximum extension. Truck 1 has a rear-mounted ladder with a maximum extension of 135 feet. Truck companies carry portable extension ladders ranging in length from 16 feet to 45 feet. They also carry an assortment of tools and appliances for forcible entry, ventilation, overhaul and salvage.

The Firefighting Division consists of:

3 Deputy Fire Chiefs
27 Battalion Fire Chiefs
54 Captains
3 Marine Engineers
3 Marine Pilots
108 Lieutenants
68 Sergeants
2 Assistant Marine Crewmen
348 Firefighting Technicians
654 Firefighters

Firefighting personnel are the primary deliverers of the Home Fire Safety Program for the Department. During FY 86, there were 12,000 survey attempts made by those personnel. This program reaches thousands of city residents with fire safety and preventive information.

Emergency Ambulance Division

The Emergency Ambulance Service was established by Commissioner's Order No. 57-166 on September 6, 1957. On November 9, 1981, the Mayor of the District of Columbia, Marion Barry Jr., issued Executive Order No. 81-233.4, establishing the Emergency Ambulance Service as a Division within the D.C. Fire Department. We have grown from seven ambulance units to 15 Basic Life Support Units and five Advanced Life Support Units. In FY'86 we placed Ambulance 20 in service as a Basic Life Support Unit at 4930 Connecticut Ave., N.W. We will place two additional Advanced Life Support Units in service in FY'87, bringing the total to seven Advanced Life Support Units and 15 Basic Life Support Units. We are responsible for the immediate medical attention, and respond to life-threatening situations involving the President, Vice President, Congress, the Mayor, District Council, their families, 626,900 residents, and a daytime population of about 965,200 persons. Our responses have increased steadily from 98,000 in FY'83 to 124,479 in FY'86. We respond to about 7,120 assaults, hazardous situations and barricades annually.

The attitude and conduct of the emergency medical personnel reflect, at all times, a sincere dedication to serve the citizens of the District of Columbia. Their moral and ethical standards are beyond reproach and they strive always to increase their knowledge and skills.

The Emergency Ambulance personnel are responsible members of a medical team. They take pride in their personal appearance, their technical knowledge, and their ability to maintain their composure and self-confidence. Emergency medical technicians, intermediate paramedics and paramedics are sympathetic to the abnormal and sometimes exaggerated actions of those under stress, and exert reasonable and firm leadership in carrying out measures that ensure the survival, comfort, and confidence of the patient until he or she is delivered to a medical treatment facility.

AMBULANCE SERVICE PROFILE

	FY'85	FY'86
Persons treated	102,260	117,909
Basic	97,592	111,979
Advanced Life Support	4,668	5,930
Performance-of-duty injuries treated	411	83
D.C. medical charity persons treated	2,118	3,145
Persons treated but not transported	48,841	49,782
Accounts receivable	$50,890	$59,072
Insufficient information obtained— (John Does and no fixed address)	2,339	1,222
Return mail	6,303	6,608
Accounts collectable for ambulance service	$42,248	$49,530
COLLECTIONS		
Medicare	$ 3,775	$ 4,089
Medicaid	7,519	8,864
Medicare/Medicaid	690	803
Self-pay	10,622	11,031
Totals	$22,606	$24,787

PROGRESS MADE IN AMBULANCE BILLING

FY	GROSS COLL.	NET TO D.C. GOV'T.
1982	$1,111,246	$ 901,903
1983	1,199,771	931,854
1984	1,357,695	1,013,031
1985	1,204,580	907,495
1986	1,250,850	943,984

AMBULANCE BILLING OPERATIONS-FISCAL YEAR 1986

REVENUE COLLECTIONS:

(a) Net to D.C. government $ 943,984
(b) Amount paid to contractor $ 306,866
(c) Gross revenue collected $1,250,850

COLLECTION RATES:

(a) Accounts Receivable 37.4%
(b) Accounts Billable 39.4%
(c) Accounts Collectable 44.5%

COMPARING FY85 TO FY86

	FY'85	FY'86	Up/Down	Percentages
Persons treated	102,260	117,909	up	13%
Basic	97,592	111,979	up	13%
Advanced Life Support	4,668	5,930	up	21%
Performance-of-duty	411	83	down	80%
D.C. medical charity	2,118	3,145	up	33%
Persons treated but not transported	48,841	49,782	up	2%
Accounts receivable	$50,890	59,072	up	14%
Insufficient information	2,339	1,222	down	48%
Billable forms	48,551	56,138	up	14%
Return mail	6,303	6,608	up	5%
Accounts collectable	$42,248	$49,530	up	15%

EAD RESPONSES:

Year	No. of EAD Units	Total Responses	Increase over prior year	Manpower
1984	17	91,921	1.0%	196 + 57 temp
1985	19	96,887	5.0%	196 + 57 temp
1986	20	102,657	6.0%	289

COST BREAKDOWN OF COLLECTIONS:

Item	Dollar Value	Percentage of Collections
Medicare	$ 172,952	13.8
Medicaid	489,774	39.1
Medicare/Medicaid	16,366	1.4
Self-Pay	571,756	45.7
Total Collected	$1,250,848	100.0

Busiest Engine Companies—1986

Rank	City	Company	Runs
1	New York	48	4933
2	Phoenix	3	4753
3	Cincinnati	5	4620
4	Milwaukee	13	4294
5	Sacramento, CA	6	3939
6	Denver	8	3745
7	Los Angeles City	46	3671
8	Tucson, AZ	5	3587
9	Washington, D.C.	10	3555
10	Minneapolis	8	3533
11	Prince Georges Cty., MD	33	3287
12	Boston	37	3200
13	Philadelphia	2	2963
14	Toledo	6	2920
15	San Francisco	3	2906
16	Providence	10	2898
17	Oakland	20	2862
18	Baltimore	46	2834
19	Newark, NJ	6	2815
20	Miami, FL	3	2769
21	Long Beach, CA	10	2760
22	San Diego	17	2712
23	Chicago	61	2873
24	San Jose, CA	8	2661
25	Buffalo	2	2533
26	Cleveland	4	2396
27	Dallas	11	2350
28	Nashville	5	2336
29	Seattle	10	2265
30	Charlotte, NC	1	2250
31	Metro-Dade Cty., FL	3	2224
32	Atlanta	11	2200
33	Largo, FL	41	2178
34	Salt Lake City	8	2175
35	Manchester, NH	11	2138
36	Dekalb Cty., GA	6	2064
37	Jacksonville, FL	10	2060
38	Anne Arundel Cty., MD	33	1999
39	Memphis	7	1978
40	Tampa	7	1959
41	Camden, NJ	7	1947
42	Detroit	50	1941
43	Indianapolis	22	1870
44	Orlando, FL	2	1855
45	Richmond, VA	5	1837
46	Columbus, OH	10	1791
47	Kansas City, MO	19	1787
48	Syracuse, NY	7	1725
49	Houston	28	1701
50	Birmingham, AL	6	1698
51	Clark Cty., NV	11	1620
52	Niles, IL	2	1596
53	Portland, OR	8	1593
54	Fairfax Cty., VA	29	1555
55	Jersey City	9	1547
56	Rochester, NY	16	1531
57	Arlington, TX	2	1521
58	Portland, ME	4	1466
59	Baltimore Cty., MD	10	1453
60	Virginia Beach, VA	11	1404
61	Cobb Cty., GA	19	1341
62	Hartford	2	1307
63	New Haven, CT	6	1244
64	Burlington, VT	1	1208
65	Gwinnett Cty., GA	11	1205
66	Worcester, MA	1	1185
67	Wilmington, DE	1	1183
68	San Antonio	8	1145
69	Anchorage, AK	1	1127
70	Louisville, KY	7	1116
71	St. Louis	2	1094
72	Trenton	10	1073
73	St. Paul	18	1070
74	Bridgeport, CT	2	1033
75	Charleston, WV	1	1010
76	Oklahoma City	24	956
77	Grand Rapids	9	953
78	Little Rock, AR	7	948
79	Youngstown, OH	7	864
80	Casper, WY	1	864
81	Tulsa	24	817
82	Honolulu	26	753
83	Mobile, AL	22	738
84	New Orleans	36	734
85	Billings, MT	4	690
86	Sioux Falls, SD	1	669
87	Wichita, KS	31	481
88	Albuquerque, NM	1	457
89	Boone Cty., MO	101	413

CANADA

1	Toronto	7	3860
2	Calgary, Alta.	1	3300
3	Vancouver, Br. Col.	2	2176
4	Winnepeg, Man.	411	1894
5	Edmonton, Alta.	5	1835
6	Ottawa, Ont.	3	1259
7	Montreal	205	1173

Total Alarms (Fire and EMS)—1986

Rank	City	Alarms
1	New York	304798
2	Chicago	293421
3	Los Angeles City	253000
4	Washington, D.C.	156912
5	Philedelphia	155538
8	Houston	142963
7	Baltimore	139426
8	Detroit	139036
9	Dallas	105209
10	Phoenix	89190
11	Jacksonville, FL	87894
12	Metro-Dade Cty., FL	86415
13	Milwaukee	82199
14	San Antonio	80804
15	Baltimore Cty., MD	70913
16	Prince Georges Cty., MD	66708
17	Columbus, OH	63656
18	Cincinnati	59207
19	Memphis	58817
20	San Francisco	57932
21	Dekalb Cty., GA	57094
22	Fairfax Cty., VA	54481
23	San Diego	51017
24	Boston	49300
25	Miami, FL	47770
26	Nashville	47713
27	Seattle	44450
28	Denver	41744
29	Portland, OR	40178
30	San Jose, CA	37393
31	Tucson, AZ	37134
32	Anne Arundel Cty., MD	36000
33	Providence	35414
34	Sacramento, CA	34845
35	Albuquerque, NM	34274
36	Oakland	33526
37	Atlanta	32424
38	Toledo	29631
39	Long Beach, CA	29530
40	Buffalo	29075
41	Indianapolis	28788
42	Cleveland	26871
43	Birmingham, AL	26527
44	Charlotte, NC	25828
45	Tampa	25788
46	Minneapolis	23807
47	Kansas City, MO	23086
48	St. Paul	23000
49	Clark Cty., NV	22117
50	Wichita, KS	19829
51	Oklahoma City	18684
52	Orlando, FL	17751
53	New Haven, CT	17735
54	Newark, NJ	16804
55	Salt Lake City	16780
56	Anchorage, AK	16674
57	Gwinnett Cty., GA	13849
58	St. Louis	13831
59	Rochester, NY	11804
60	Bethesda-Chevy Chase Res. Sq., MD	11362
61	Virginia Beach, VA	11355
62	New Orleans	11116
63	Arlington, TX	10958
64	Tulsa	10670
65	Portland, ME	10324
66	Worcester, MA	10146
67	Mobile, AL	9935
68	Cobb Cty., GA	9475
69	Richmond	9463
70	Honolulu	9295
71	Largo, FL	8829
72	Syracuse, NY	8452
73	Hartford	8393
74	Jersey City	8265
75	Camden, NJ	8237
76	Louisville, KY	8028
77	Youngstown, OH	7294
78	Manchester, NH	7272
79	Little Rock, AR	7020
80	Bridgeport, CT	6535
81	Grand Rapids	5192
82	Burlington, VT	4778
83	Trenton	4378
84	Niles, IL	3243
85	Charleston, WV	2943
86	Wilmington, DE	2878
87	Sioux Falls, SD	2701
88	Casper, WY	2236
89	Billings, MT	2142
90	Boone Cty., MO	1608

CANADA

Rank	City	Alarms
1	Toronto	33394
2	Vancouver, Br. Col.	23353
3	Winnipeg, Man.	17331
4	Edmonton, Alta.	14298
5	Montreal	14263
6	Calgary, Alta.	9385
7	Ottawa, Ont.	7353

Annual Department Budgets—1986

Rank	City	($) Budget
1	New York	557,300,941
2	Los Angeles Cty.	199,000,000
3	Los Angeles City	191,000,000
4	Chicago	178,521,333
5	San Francisco	124,519,258
6	Houston	114,756,000
7	Philadelphia	91,259,913
8	Dallas	82,297,952
9	Baltimore	77,136,622
10	Metro-Dade Cty., FL	69,218,000
11	Boston	69,000,000
12	Washington, D.C.	66,472,023
13	Milwaukee	55,341,739
14	Miami	51,525,000
15	Phoenix	51,300,000
16	San Diego	50,757,910
17	Memphis	49,694,334
18	Cleveland	45,900,000
19	Long Beach, CA	45,118,067
20	Denver	44,599,900
21	San Jose, CA	44,000,000
22	Seattle	43,500,000
23	Oakland	42,514,632
24	Fairfax Cty., VA	41,544,300
25	Columbus, OH	38,132,197
26	Jacksonville, FL	37,954,157
27	Portland, OR	37,815,312
28	New Orleans	37,000,000
29	Baltimore Cty., MD	34,661,449
30	Kansas City, MO	32,747,325
31	Atlanta	30,643,247
32	Anchorage, AK	29,308,070
33	Honolulu	28,917,660
34	Indianapolis	28,388,333
35	Sacramento, CA	28,191,000
36	Anne Arundel Cty., MD	27,796,040
37	Cincinnati	27,238,556
38	Buffalo	26,979,056
39	Tucson, AZ	26,218,050
40	Newark, NJ	26,000,000
41	Minneapolis	25,764,004
42	Tulsa	25,500,000
43	Toledo	25,000,000
44	Dekalb Cty., GA	25,000,000
45	Oklahoma City	23,521,919
46	Nasbville	23,500,000
47	St. Louis	22,379,681
48	Rochester, NY	21,600,000
49	Charlotte, NC	21,316,780
50	Birmingham, AL	20,835,266
51	Richmond	20,210,791
52	Albuquerque, NM	19,215,632
53	Louisville, KY	18,628,370
54	Tampa	18,560,000
55	Bridgeport, CT	18,111,023
56	Hartford	17,700,000
57	New Haven, CT	16,575,133
58	St. Paul	16,154,170
59	Providence	15,873,724
60	Syracuse, NY	15,499,716
61	Orlando, FL	15,247,377
62	Cobb Cty., GA	15,000,000
63	Salt Lake City	14,900,000
64	Gwinnett Cty., GA	14,714,601
65	Virginia Beach, VA	14,366,117
66	Worcester, MA	13,077,841
67	Arlington, TX	12,935,714
68	Grand Rapids	12,135,480
69	Mobile, AL	11,618,309
70	Wichita, KS	11,315,837
71	Little Rock, AR	8,783,485
72	Trenton	8,634,730
73	Wilmington, DE	7,600,000
74	Youngstown, OH	7,000,000
75	Largo, FL	5,735,184
76	Sioux Falls, SD	4,904,596
77	Portland, ME	4,800,000
78	Charleston, WV	4,440,597

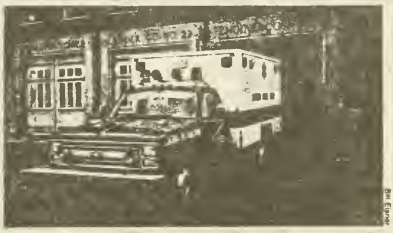
CANADA

1	Montreal	77,820,000
2	Toronto	64,600,000
3	Calgary, Alta.	58,551,000
4	Edmonton, Alta.	53,573,000
5	Winnipeg, Man.	40,974,745
6	Vancouver, Br. Col.	39,031,000
7	Ottawa, Ont.	27,169,500

(continued on page 88)

Busiest Ambulance/Paramedic Units—1986

Rank	City	Unit	Runs
1	Detroit	Medic 15	8250
2	Baltimore	7	7592
3	Washington, D.C.	Amb. 17	7457
4	Cleveland EMS	Medic 9	7318
5	Columbus, OH	Squad 8	6570
6	Philadelphia	R-13	6416
7	Los Angeles City	RA-9	6410
8	Chicago	36	5578
9	Tucson, AZ	Medic 4	5563
10	Providence	R-3	5346
11	Portland, OR	R-1	5261
12	Metro-Dade Cty., FL	2	5238
13	Dallas	703	5225
14	New Haven, CT	E-1	4942
15	Phoenix	A-9	4940
16	Prince Georges Cty., MD	R-3	4841
17	Miami, FL	R-9	4814
18	Long Beach, CA	10	4680
19	Nashville	Medic 5	4490
20	Houston	A-25	4487
21	Clark Cty., NV	R-11	4475
22	San Diego	H-311	4359
23	Milwaukee	Medic 5	4310
24	Albuquerque, NM	R-3	4270
25	San Antonio	807	4216
26	Tampa	R-1	3833
27	Portland, ME	Medic 3	3754
28	Orlando, FL	R-2	3676
29	Youngstown, OH	Medic 55	3618
30	Dekalb Cty., GA	Medic 3	3617
31	Memphis	4	3539
32	Charleston, WV	930	3519
33	Seattle	Aid 5	3511
34	Jacksonville, FL	R-6	3416
35	Anchorage, AK	Medic 3	3070
36	Baltimore Cty., MD	MU-7	3017
37	Fairfax Cty., VA	11	2559
38	Burlington, VT	R-1	2503
39	Cincinnati	38	2451
40	St. Paul	Medic 22	2374
41	Anne Arundel Cty., MD	PM-22	2257
42	Largo, FL	R-47	2222
43	Salt Lake City	8	2175
44	Birmingham, AL	6	2132
45	Toledo	LS2	1895
46	Atlanta	Echo 1	1695
47	Niles, IL	A-2	1647
48	Gwinnett Cty., GA	Medic 11	1428
49	Boone Cty., MO	Medic 20	377
50	Sioux Falls, SD	R-1	113



Bill Burns

INTRODUCING

Busiest Chiefs—1986

Rank	City	Chief	Runs
1	Boston	5	7100
2	New York	9	5267
3	Denver	2	3807
4	Philadelphia	8	3813
5	Birmingham, AL	51	3608
6	Charleston, WV	54	2943
7	Chicago	13	2760
8	Phoenix	2	2711
9	Atlanta	903	2076
10	Newark	1	2060
11	Los Angeles City	1	1974
12	Seattle	1	1911
13	Cincinnati	1	1870
14	Washington, D.C.	6	1775
15	Richmond, VA	1	1772
16	San Francisco	1	1627
17	Rochester, NY	2	1551
18	Syracuse, NY	4	1544
19	Miami, FL	2	1522
20	Dallas	1	1519
21	St. Louis	805	1507
22	New Haven, CT	West	1488
23	Worcester, MA	3	1460
24	Buffalo	4	1452
25	Long Beach, CA	1	1400
26	Indianapolis	D 3	1392
27	Camden, NJ	1	1351
28	Louisville, KY	C-53	1339
29	Providence	3	1338
30	Kansas City, MO	106	1325
31	Hartford	3	1304
32	Baltimore	2	1270
33	Detroit	5	1234
34	Largo, FL	41	1157
35	Orlando, FL	1	1077
36	Jersey City	2	995
37	Grand Rapids	5	991
38	Gwinnett Cty., GA	201	983
39	Houston	8	972
40	Burlington, VT	12	927
41	New Orleans	302	910
42	Oakland	3	905
43	Baltimore Cty.	5	897
44	Fairfax Cty., VA	2	791
45	Anne Arundel Cty., MD.	1	774
46	Milwaukee	5	771
47	Tulsa	Dist. 1	756
48	Anchorage, AK	1	755
49	Tucson, AZ	1	720
50	San Diego	2	713
51	Metro-Dade Cty., FL	3	701
52	Nashville	9	698
53	Jacksonville, FL	7	692
54	Toledo	6	638
55	Arlington, TX	1	622
56	Billings, MT	1	593
57	Trenton	5	561
58	Niles, IL	202	508
59	Youngstown, OH	31	477
60	San Jose, CA	5	405

CANADA

1	Toronto	41	3054
2	Ottawa, Ont.	24	2421
3	Winnipeg, Man.	51	2415
4	Montreal	123	2058
5	Vancouver, Br. Col.	2	1312
6	Calgary, Alta.	16	223

Total Fire Calls

Rank	City	Alarms
1	Chicago	101299
2	New York	94157
3	Philadelphia	56610
4	Washington, D.C.	54255
5	Baltimore	51273
6	Jacksonville, FL	48918
7	Detroit	38419
8	San Francisco	34395
9	Dallas	31235
10	Dekalb Cty., GA	28340
11	Memphis	25590
12	Phoenix	25281
13	Baltimore Cty., MD	24812
14	Los Angeles City	22752
15	Miami, FL	16991
16	Atlanta	15083
17	Prince Georges Cty., MD	15074
18	Providence	13728
19	Fairfax Cty., VA	13666
20	Columbus, OH	13273
21	Milwaukee	13008
22	Seattle	12923
23	Nashville	12410
24	Metro-Dade Cty., FL	11406
25	St. Louis	11242
26	New Orleans	11116
27	Boston	11066
28	Buffalo	10792
29	Anne Arundel Cty., MD	9636
30	San Antonio	9266
31	Albuquerque, NM	8297
32	Indianapolis	8249
33	Camden, NJ	8237
34	Birmingham, AL	8034
35	Cleveland	7881
36	Richmond	7831
37	Toledo	6820
38	St. Paul	6784
39	Anchorage, AK	6145
40	Newark, NJ	6005
41	Minneapolis	5644
42	San Diego	5467
43	New Haven, CT	5302
44	Oklahoma City	5297
45	Kansas City, MO	5176
46	Oakland	5129
47	Long Beach, CA	5094
48	Worcester, MA	5066
49	Denver	5017
50	Little Rock, AR	4905
51	Salt Lake City	4885
52	Bridgeport, CT	4533
53	Manchester, NH	4413
54	Houston	4206
55	Tucson, AZ	4127
56	Portland, ME	4068
57	Portland, OR	4028
58	Grand Rapids	3794
59	Trenton	3761
60	Jersey City	3618
61	Youngstown, OH	3553
62	Arlington, TX	3526
63	Gwinnett Cty., GA	3521
64	Honolulu	3518
65	Cincinnati	3512
66	San Jose, CA	3458
67	Virginia Beach, VA	3284
68	Tulsa	3197
69	Charlotte, NC	3149
70	Charleston, WV	2943
71	Mobile, AL	2706
72	Burlington, VT	2376
73	Clark Cty., NV	2344
74	Sioux Falls, SD	2304
75	Cobb Cty., GA	2276
76	Rochester, NY	2217
77	Billings, MT	2142
78	Hartford	2111
79	Wichita, KS	1786
80	Tampa	1784
81	Syracuse, NY	1777
82	Orlando, FL	1351
83	Niles, IL	1269
84	Wilmington, DE	1259
85	Louisville, KY	1155
86	Sacramento, CA	1002
87	Boone Cty., MO	784
88	Largo, FL	422
89	Casper, WY	265

CANADA

1	Calgary, Alta.	9385
2	Edmonton, Alta.	7158
3	Vancouver, Br. Col.	4971
4	Montreal	4324
5	Toronto	3419
6	Winnipeg, Man.	3180
7	Ottawa, Ont.	1494

Total EMS Calls—1986

Rank	City	Calls
1	Los Angeles City	191757
2	Chicago	181421
3	Washington, DC	102657
4	Houston	100957
5	Detroit	100617
6	Philadelphia	98928
7	Baltimore	88153
8	Dallas	73974
9	Metro-Dade Cty., FL	68649
10	Cleveland EMS	65209
11	Phoenix	63909
12	San Antonio	57171
13	Columbus, OH	50383
14	Prince Georges Cty., MD	49542
15	Baltimore Cty., MD	45905
16	Milwaukee	40659
17	Jacksonville, FL	38976
18	Fairfax Cty., VA	37416
19	San Diego	37156
20	Memphis	33227
21	Nashville	32999
22	Seattle	31527
23	Miami	30779
24	Dekalb Cty., GA	28493
25	Albuquerque, NM	25977
26	Portland, OR	25917
27	Anne Arundel Cty., MD	25866
28	Tucson, AZ	25693
29	Cincinnati	24631
30	Long Beach, CA	24352
31	Oakland	24172
32	Toledo	22811
33	San Jose, CA	21059
34	Tampa	20963
35	Indianapolis	19745
36	Denver	19622
37	Birmingham, AL	18417
38	Buffalo	18283
39	Clark Cty., NV	17565
40	Atlanta	17341
41	St. Paul	16216
42	Providence	15652
43	Charlotte, NC	15404
44	Minneapolis	15255
45	Wichita, KS	14179
46	San Francisco	13400
47	Sacramento, CA	13109
48	Orlando, FL	12562
49	New Haven, CT	12414
50	Salt Lake City	11922
51	Charleston, WV	11089
52	Anchorage, AK	10529
53	Kansas City, MO	9731
54	Bethesda-Chevy Chase Res Sq., MD	8969
55	Oklahoma City	7631
56	Arlington, TX	6658
57	Largo, FL	6306
58	Portland, ME	6256
59	Cobb Cty., GA	6019
60	Mobile, AL	5861
61	Virginia Beach, VA	5064
62	Boston	4788
63	Cleveland FD	4338
64	Youngstown, OH	3741
65	Honolulu	2876
66	Manchester, NH	2859
67	Burlington, VT	2402
68	Rochester, NY	2397
69	Gwinnett Cty., GA	2162
70	Little Rock, AR	2115
71	Niles, IL	1974
72	Casper, WY	1479
73	Bridgeport, CT	1426
74	Grand Rapids	1398
75	Tulsa	1276

CANADA

1	Vancouver, Br. Col.	15581
2	Toronto	15158
3	Montreal	9265
4	Edmonton, Alta.	6889
5	Winnipeg, Man.	3125

EMT/Paramedic Pay—1986

City	Starting Pay	Top Pay
Albuquerque, NM	19,462	23,645
Anchorage, AK	34,012	48,601
Anne Arundel Cty., MD	23,324	32,053
Arlington, TX	21,362	21,362
Atlanta	18,324	29,047
Baltimore	19,311	27,047
Baltimore Cty., MD	23,049	34,233
Birmingham, AL	19,884	24,128
Burlington, VT	15,470	21,740
Charleston, WV	15,956	21,499
Chicago	22,865	36,705
Cincinnati	29,593	30,710
Clark Cty., NV	22,425	29,935
Columbus, OH		25,334
Dallas	27,048	31,244
Dekalb Cty., GA	19,560	27,552
Fairfax County, VA	21,028	31,068
Gwinnett Cty., GA	20,000	29,118
Houston	21,934	29,601
Indianapolis	13,500	26,290
Jacksonville, FL	19,452	26,076
Largo, FL	18,782	26,732
Long Beach, CA	28,632	39,660
Los Angeles City	20,688	37,392
Los Angeles Cty.	31,409	39,293
Memphis	23,523	25,875
Metro-Dade Cty., FL	27,373	36,411
Miami, FL	25,487	40,229
Milwaukee	19,157	27,957
Mobile, AL	16,572	25,584
Nashville	16,632	25,008
New Haven, CT	22,881	29,062
Niles, IL	28,011	32,394
Orlando, FL	22,367	26,152
Philadelphia	26,548	28,010
Phoenix	32,096	32,096
Portland, ME (FM)	16,096	21,729
Portland, OR	22,298	34,528
Prince Georges Cty., MD	17,085	29,342
Providence	22,000	28,000
St. Paul	25,150	34,010
Salt Lake City	22,320	34,452
San Diego	18,000	28,830
Seattle	33,132	33,132
Tampa	20,766	26,000
Toledo	23,522	30,927
Tucson, AZ	28,008	29,412
Washington, D.C.	19,117	32,116
Wichita, KS	19,621	24,541

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SPECIAL PAY RATES

WITHIN THE SCOPE OF COLLECTIVE BARGAINING

Effective: December 21, 1986

Occupational Coverage:

EMERGENCY MEDICAL TECHNICIAN
INTERMEDIATE TECHNICIAN
PARAMEDIC
FIRE DEPARTMENT ONLY
SERVICE CODE: A03

Grade	1	2	3	4	5	6	7	8	9	10
DS-6	$19,117	$19,679	$20,241	$20,803	$21,365	$21,927	$22,489	$23,051	$23,613	$24,175
DS-7	20,616	21,242	21,868	22,494	23,120	23,746	24,372	24,998	25,624	26,250
DS-8	22,834	23,527	24,220	24,913	25,606	26,299	26,992	27,685	28,378	29,071
DS-9	25,222	25,988	26,754	27,520	28,286	29,052	29,818	30,584	31,350	32,116

SPECIAL PAY RATES

WITHIN THE SCOPE OF COLLECTIVE BARGAINING

Effective: September 27, 1987

Occupational Coverage:

EMERGENCY MEDICAL TECHNICIAN
INTERMEDIATE TECHNICIAN
PARAMEDIC
FIRE DEPARTMENT ONLY
SERVICE CODE: A03

Grade	1	2	3	4	5	6	7	8	9	10
DS-6	$19,393	$19,963	$20,533	$21,103	$21,673	$22,243	$22,813	$23,383	$23,953	$24,523
DS-7	20,913	21,548	22,183	22,818	23,453	24,088	24,723	25,358	25,993	26,628
DS-8	23,163	23,866	24,569	25,272	25,975	26,678	27,381	28,084	28,787	29,490
DS-9	25,586	26,363	27,140	27,917	28,694	29,471	30,248	31,025	31,802	32,579

OUTSIDE THE SCOPE OF COLLECTIVE BARGAINING

SCHEDULE I

DISTRICT SERVICE SCHEDULE

Effective: October 12, 1986

GRADE	1	2	3	4	5	6	7	8	9	10
DS 1	$ 9,816	$10,144	$10,472	$10,800	$11,128	$11,456	$11,784	$12,112	$12,440	$12,768
2	11,046	11,411	11,777	12,143	12,509	12,875	13,241	13,607	13,973	14,339
3	12,050	12,461	12,862	13,253	13,654	14,055	14,456	14,857	15,258	15,659
4	13,625	13,976	14,427	14,878	15,329	15,780	16,231	16,682	17,133	17,584
5	16,124	16,631	16,138	16,645	17,152	17,659	18,166	18,673	19,180	19,687
6	16,869	17,431	17,993	18,555	19,117	19,679	20,241	20,803	21,365	21,927
7	18,738	19,364	19,990	20,616	21,242	21,868	22,494	23,120	23,746	24,372
8	20,755	21,448	22,141	22,834	23,527	24,220	24,913	25,606	26,299	26,992
9	22,924	23,690	24,456	25,222	25,988	26,754	27,520	28,286	29,052	29,818
10	25,252	26,093	26,934	27,775	28,616	29,457	30,298	31,139	31,980	32,821
11	27,748	28,671	29,594	30,517	31,440	32,363	33,286	34,209	35,132	36,055
12	33,250	34,358	35,466	36,574	37,682	38,790	39,898	41,006	42,114	43,222
13	39,541	40,858	42,175	43,492	44,809	46,126	47,443	48,760	50,077	51,394
14	46,725	48,282	49,839	51,396	52,953	54,510	56,067	57,624	59,181	60,738
15	54,959	56,791	58,623	60,455	62,287	64,119	65,951	67,783	69,615*	71,447*
16	64,456	66,605	68,754*	70,903*	73,052*	75,201*	77,350*	79,499*	81,648*	
17	75,509*	78,026*	80,543*	83,010*	83,010*					
18	83,010*									

* The rate of basic pay shall not exceed $69,567 through September 26, 1987.

OUTSIDE THE SCOPE OF
COLLECTIVE BARGAINING

SCHEDULE I

DISTRICT SERVICE SCHEDULE

Effective: September 27, 1987

GRADE		1	2	3	4	5	6	7	8	9	10
OS	1	$9,957	$10,290	$10,623	$10,956	$11,289	$11,622	$11,955	$12,288	$12,621	$12,954
	2	11,205	11,576	11,947	12,318	12,689	13,060	13,431	13,802	14,173	14,544
	3	12,223	12,630	13,037	13,444	13,851	14,258	14,665	15,072	15,479	15,886
	4	13,722	14,179	14,636	15,093	15,550	16,007	16,464	16,921	17,378	17,835
	5	15,343	15,857	16,371	16,885	17,399	17,913	18,427	18,941	19,455	19,969
	6	17,113	17,683	18,253	18,823	19,393	19,963	20,533	21,103	21,673	22,243
	7	19,008	19,643	20,278	20,913	21,548	22,183	22,818	23,453	24,088	24,723
	8	21,054	21,757	22,460	23,163	23,866	24,569	25,272	25,975	26,678	27,381
	9	23,256	24,032	24,809	25,586	26,363	27,140	27,917	28,694	29,471	30,248
	10	25,617	26,470	27,323	28,176	29,029	29,882	30,735	31,588	32,441	33,294
	11	28,148	29,085	30,021	30,957	31,893	32,829	33,765	34,701	35,637	36,573
	12	33,733	34,856	35,979	37,102	38,225	39,348	40,471	41,594	42,717	43,840
	13	40,111	41,447	42,783	44,119	45,455	46,791	48,127	49,463	50,799	52,135
	14	47,397	48,977	50,557	52,137	53,717	55,297	56,877	58,457	60,037	61,617
	15	55,753	57,611	59,469	61,327	63,185	65,043	66,901	68,759	70,617*	72,475*
	16	65,386	67,566	69,746*	71,926*	74,106*	76,286*	78,466*	80,646*	82,826*	
	17	76,599*	79,152*	81,705*	83,010*	83,010*					
	18	83,010*									

* The basic rate of pay shall not exceed $69,556.

D.C. FIRE FIGHTERS *Communications Update:*

As a result of numerous complaints from members at the 300 McMillan Drive location, a meeting was held recently with the Fire Department and the D.C. Office of Labor Relations. The following is a synopsis of what was discussed, what was committed to, and what has happened to date.

1. The Union advised the Department that the ambulance status board has not operated properly for more than five (5) months. The Department committed to getting it fixed promptly. As of February 24, the board is still in the same non-functioning condition.

2. The Union expressed concern over Chief Archer's memo of January 12, 1987 that was interpreted as requiring dispatchers to request permission from a supervisor to go to the bathroom. Chief Archer committed to meeting with each crew and advising the dispatchers that the lead operator or supervisor should know where they are going so someone could back them up. Chief Archer did meet with at least 3 of the crews and the problem has been apparently resolved.

3. The Union expressed concern over the inability of members to get emergency annual leave. The Department committed to being more flexible in granting emergency leave and to date no more problems over this issue have been referred to the Local.

4. The Department stated they had a necessity to bring uniformed lieutenants up to communications to help supervise. The Union was and is opposed to this, and offered several alternatives to the Department's action. They committed to insuring it would only be for a short period of time. As of February 24, there were still lieutenants supervising, but it has been indicated that it will just be for a short time longer.

5. The dispatchers have complained repeatedly that there is not a decent typewriter on the floor for filing required reports. The Department stated that they had tried to get another typewriter, but to no avail. Labor Relations committed to assisting in the procurement of a good quality typewriter. As of February 24th the same old typewriter is still there.

6. The Union complained that there was no constructive drill time taking place on any of the four crews. The Department committed to conducting meaningful drills for the dispatchers. As of February 24th, 3 of the crews are conducting drills, and only one supervisor, Tom Burke, is not complying with the intent of the training article of the contract.

7. The Union reminded the Department that there is an ongoing problem with glare from the video display terminals and supplied them with the name and telephone number of a supplier of velcro attachable screens to help reduce the glare until the lighting and seating could be corrected. As of February 24th, it is the Union's understanding that the screens have been ordered.

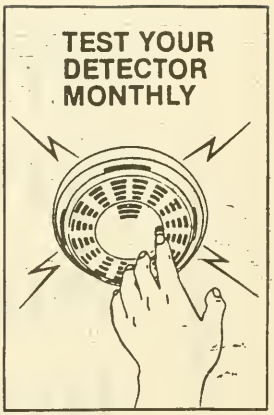
8. The Union advised the Department of an ongoing problem of police dispatchers refusing to answer calls from fire dispatchers. Chief Archer committed to meeting with the appropriate level of supervision in police communications to resolve this problem. The results of that meeting are not known at this time.

9. The Union reminded the Department of their duty to maintain sleeping facilities at 300 McMillan Drive. The Department committed to replacing the furniture that was removed. To date, nothing has been done.

10. The Union advised the Department that it is inappropriate to post MIP leave revocations and/or status of all employees. The Department committed to ceasing the practice, and they have done so.

11. The Union expressed concern that the Department was not maintaining EMT certifications or training new employees in EMT school. The Department acknowledged that there is a need for the training, or at the very least, certain parts of it, for dispatchers to be able to adequately and professionally do their jobs. They committed to sending people to EMT training and to formulating a glossary of terms for new employees until EMT training can be scheduled. To date, the Union is not aware of anything taking place.

There were a number of other issues discussed with the Department that we are hopeful will be resolved in the very near future. Of the items listed above that no action has been taken by the Department, grievances are being filed. If you know of any other issues that affect your ability to perform your job or are detrimental to your working conditions, please advise the Local and we will attempt to get them resolved.



LOCAL COMMITTEES FORMING

Local 2336 is preparing to staff its Entertainment, Fund Raising and Public Relations Committees. These committees are made up of volunteers from among our members and stewards and provide service to the Local and membership. Committees are interesting, educational and even exciting. Committee work is done after hours and other non-duty time and does not require any special abilities.

"WHAT adverse effects from buying a Toyota?"

TO: Theodore R. Coleman
Fire Chief

DEPARTMENT, Fire

AGENCY, OFFICE: CD

FROM: Charles Culver cc
Battalion Chief

DATE: March 31,1987

SUBJECT: Recommendations for Communications Division.

To address the problems of the present CAD System, the needs for present and future operations, and possible solutions, I submit to you the following study:

The present CAD System, housed at 300 McMillian Drive, N.W., went into operation in the early 70's, and was done in two parts (2 different companies) the ambulance side was done first, and then the fire dispatch side was hooked up. This was done (fire side) by a California company . The system was made by ITT, and was not hooked up as per their diagrams, so working on the system cannot be done by our technicians because the diagrams are not as ITT, instructed the California company to hook up the system. The system is so out of line that other electronic companies refuse to work on it.

I then began to talk to people using the system, looking for ideas on how to improve it, knowing that in the near future, the department is looking to replace the old system, with a new one, also knowing that when the users help identify the problems with the old system, and help design the new system, they have an interest to protect and will support most changes coming as a result of the project. The dispatchers were able to identify problems with the system and many had good ideas on what could be done to assist them in quality dispatching. The following is the complaints submitted to me and recommendations, following their recommendations are my recommendations and comments.

TO:

FROM:

SUBJECT:

COMPLAINTS BY PERSONNEL

1. Members have never been crossed trained.
2. Some have never drilled on Mass Casualty Plan.
3. Lack of proper supervision.
4. Members feel over-worked and underpaid.
5. Had no, input in Priority Dispatch System.
6. Equipment not working properly.
7. S.O. 5,1987, never circulated to Firefighting Division.
8. Ambulance not following memo. ties up to much air time.
9. Portable radio's do not work, sometime.
10. Minimum of three (3) ambulances are out of service per shift.
11. Members eating at the console, causing more stress.
12. Noise level and cold condition of room, causes stress.
13. Favoritism, shown to some employees.
14. No open door policy, by management.
15. Sick leave abuse.
16. No chain of command, orders can come from anyone.
17. Priority Dispatch, not working, needs fine tuning.
18. 911 calls from police, sometime incomplete, or not received at all
19. Does not have proper facilities to dress.
20. Need for more personnel.
21. Lighting in room is bad.
22. Micro Wave, being in the lounge, not in the kitchen.
23. T.V. being taken off floor.
24. Moral problem.
25. A Standard operation needed for all crews.
26. Need for new head sets.
27. Hours to long without a break.
28. With no T.V. members cannot keep up with current events.
29. Employee's that don't care.
30. Callers not wanting to give dispatchers information.
31. Members refusing to work because of restraints.
32. Need for more supervisors on floor.
33. All personnel should be retrained periodically.
34. No female supervisors or leaders.
35. No BLACK supervisors.

36. No real lunch break.
37. Writing of incidents that could be handled some other way.
38. E-911, not being up-dated by telephone company as per contract.
39. Parts are hard to get for old ambulance equipment, so technicians cannot fix some things.

Recommendations from personnel

1. Drapes around walls, would help noise level, and hold some heat.
2. I.D. should be worn by all personnel in or entering building.
3. Time should begin after, dispatcher finish getting information.
4. 911 for police and 311 for fire department.
5. Need fire channel 4, transmitter capability on ambulance side.
6. Crews should meet at least once a month.
7. Need for a better back-up system, when computers are down.
8. Intercom for floor.
9. A comprehensive training program.
10. Members should be rotated every two hours.
11. Need for cross-training in all areas of department.
12. Closer working relationship between ambulance and C.D.
13. Need to review promotional process at communication Division.
14. Incidents that could be handled without writing, should be.
15. Lunch should be a minimum of 30 min., with no eating at consoles.
16. Members on floor should sit on committees making recommendations concerning them.
17. Repair or replace all personnel lockers.
18. Improve lighting on parking lot, and around building.
19. Educate public in use of 911, and use of Emergency Ambulance.
20. Return T.V. to floor, with automatic mute controlled by dispatcher.
21. One drill per night, fire side one night and Ambulance side next night.
22. Back-up should consist of Micro-Film.
23. Separate call takers and radio dispatchers.
24. Up-date operating manual.

25. All complaints should be in writing, and sworn too, from outside the department, before the department takes any action against any employee.

26. All members of the communications Division should be trained before, firefighting personnel.

27. More drills on Metro Boxes.

28. Simulators needed to train personnel, and it should be done away from communications Division.

29. Probationers should be rated just as firefighter probationers are, monthly throughout their probationary year.

30. Raise needed to attract qualified people.

31. A higher back chair for comfort.

32. Awards should be given for excellence.

33. Do away with ambulance repeating address three (3) times, takes up too much air time.

34. Emergency fold up cots, should members have to stay over due to weather, or other emergency conditions.

35. A good look at the 800 series before it is installed, to make sure that it is compatible with current G.E. system.

36. Add three (3) people to radio shop: a) Stock man, b) Electrician trainee, c) Electrical technician

37. Before installing any new equipment, call in a Project Engineer to set up system.

38. Equipment being replaced, or turned in, should be one for one to receive, too much equipment is being lost. If lost, member should be held accountable and made to pay, this would make members check to see if equipment is there before, assuming duty.

39. Re-stock radio room with parts, after hiring a stock clerk, with guidelines concerning issuants of parts etc.

40. Drills should be held monthly, by each shift on manual operations.

Equipment

All equipment that is broken or not working properly, should be fixed at once, this would be a top priority item.

Training

Have staff conduct a task analysis for the position of dispatcher to ascertain what skills are required to perform adequately as an emergency operator. The department should develop a training package which would prepare the student operator

to effectively, efficiently, and courteously elicit information in a prescribed sequence under stressful conditions. The volume of work substantially adds to the degree of stress incurred. (the division receives approximately 300 calls per day)

The prepared curriculum should eventually include political science, law, and most importantly, social science. The weakness observed in the existing Priority Dispatch system appears to revolve around the operators inability to properly extract information from the caller, and this has resulted in complaints of discourtesy and inefficiency.

A four hour training block in Transactional Analysis, should enable the student to identify the ego state of a caller, and respond in a complimentary manner, which would reduce the possibility of emotional and verbal friction between caller and operator. Victimalogy and Crisis Intervention should also be included, approximately 30 hours of training should enable the student to effectively elicit necessary information from any caller.

Maintaining manual skills in a CAD operation

Maintaining manual skills are not just for those with experience, but also for new employees, the use of manual operations should be taught. The probationer should have to demonstrate manual dispatching skills in order to complete probation, because they are going to have to use the manual system on occasion, and they must be ready to do dispatching, just like the experienced dispatchers. Immediate measures should be taken to effect refresher training and practical application in manual methods of operations.

This report was compiled from interviews and observation by me of the operation as I see it. It is not, nor is it intended to be an answer to the ills that we are facing now, it's only a suggestion, and should be taken as such.

TO: T.R. Coleman
Fire Chief

DEPARTMENT, Fire

AGENCY,OFFICE: CD

FROM: Charles Culver CC
Battalion Chief

DATE: April 6,1987

SUBJECT: Medical Miranda, Dispatch System for Communications Division.

In order to send the appropriate response mode and unit configuration, central dispatch needs initially the following minimal information from citizens and police:

a) Patient complaint/incident type.

b) Age

c) Breathing (difficulty?)

d) Conscious? (alert?)

Additional/optional information of use:

a) Medical case and age over 35: Is chest pain present?

Trauma/injury case:

b) Uncontrolled hemorrhage

How do most paramedic providers respond, when asked by police or a civilian to send a paramedic? They send over the paramedic, of course. But how did the dispatcher assess the need for paramedics, was it a trauma case, what will ALS personnel add to the victim's definitive care? Do they really mean they needed advanced life support?

The practice of sending paramedics on request is finally disappearing, and it makes sense. Often the person calling don't clearly understand that paramedics aren't just better EMT's but they offer specific additional treatment adjunts. That they add little to the treatment of most non-critical trauma is not usually perceived.

A request for "paramedics" means that emergency medical help is needed. The dispatcher should be trained to know just what is needed, and to send that. Using the system above, dialogue between callers and dispatchers could be cut to a minimum and help would be on it's way.

Start with the four commandments of medical dispatch, 1) chief complaint, 2) age, 3) status of consciousness and 4) status of breathing. In the case of trauma, is uncontrollable

hemorrhage present? If medical, does the victim have chest pain?

The subsequent result should be,better initial information and fewer relays of questions between caller and dispatchers. Should this suggestion be accepted, a game plan involving some definitive methods to effect the necessary instruction and, as a result the desired change should be undertaken.

TRAINING

CPR training for all communications personnel, followed by an intensive in-service training program in the use of the "Medical Miranda" system. The in-service program should incorporate portions of the first-responder course to supply needed background to communications personnel.

Feedback from in-service training classes should be instrumental in streamlining the "Medical Miranda" dispatch program to best fit the needs of the agency by, 1) documenting key questions to be asked, based on the patient's chief medical complaint, the system ensures consistent questioning by personnel, 2) based on the caller's response to the key questions, the operator can determine the proper level of medical response, and thus best utilize the varied levels of medical expertise available, 3) after this information is passed on, the operator can provide basic pre-arrival instructions that can help the caller stabilize the victims or even save lives in the critical time period prior to the arrival of the EAD personnel.

Mr. FAUNTROY. May we have our next witness, please.

TESTIMONY OF FRANK M. FISHBURNE, PRESIDENT, AFGE LOCAL 3721, AMBULANCE DRIVER

Mr. FISHBURNE. Good evening, sir, and members of the panel. My name is Frank Fishburne. I'm president of Local 3721. Two members that are with me: To my left, Mr. Haupt; to my right, Mr. Goldstein. The reason they didn't present any testimony is because they are with me in case there is something that I really don't have the answer to.

I'd like to have the statement entered into the record, and I will only briefly read a short part of the statement.

Mr. FAUNTROY. Without objection, so ordered. Mr. Fishburne's statement will be entered in the record.

Mr. FISHBURNE. I thank you for inviting us to speak on a group today about the problems concerning the employees of the emergency ambulance bureau, the District of Columbia Fire Department, and concerning the services we render to the public and the problems we face in rendering speedy and effective care to the citizens.

Several months ago the attention of the city was focused on what the media called a 911 crisis in the emergency ambulance system. This crisis did not arise suddenly. It has existed for years and still continues today, causing a number of exceedingly long responses and unprofessional handling of 911 calls.

I would like to review today the inadequacies of these responses to the problems. No longer can a chief use the EAB as a stepping stone to a higher ground in firefighting. The time has come for a person, be it firefighter or civilian, to have the administrative qualities and medical direction needed to take the EAB out of the ambulance era and into the EMS age.

From here, sir, I'd like to expound on just a few items. The first one is: At the present time the 5 medic units and 16 basic units serve approximately 650,000 residents of this city on any given day, or at least that is the assumption, when in actuality on any given day in the city, we serve nearly 1 million people in this city.

Last year alone, we did over 124,000 runs. However, in these 124,000 runs we ran into a lot of problems, the next problem being specifically communications which I would venture to say you've heard enough about, but I need to expound on a little more from the street aspect.

In the ambulance service you have one frequency. On the fire side, you have four frequencies. At the present time the ambulance operates on one of those four frequencies as a backup outside of the unit. I have to kind of draw you a picture of this.

You have the ambulance dispatchers on one side of a room, and the fire dispatchers on another side of the room. So once I leave my unit, I am now from this side of the room over here, barring any fires. If they have a fire, I'm nowhere.

We get our runs on one channel. We have no problems getting those runs. The problem that we have is when a unit tries to go in service, when a unit tries to relay information to communications

regarding their patient, when a unit is in trouble. That is where we run into our problems with one channel.

At the present time, most of the portables which are on Channel 4 doesn't work. So you now run into a secondary problem. If you can't get in on your primary frequency, you try on your secondary frequency. If they have a fire going anywhere in this city at the same time that you have a problem with your patient, you cannot get in on Channel 4. The radios are not designed to override the fire primary channel.

Now I understand that they're talking about putting the fire 4 into the ambulance units with repeaters. I don't understand how that is going to still override the primary fire channel.

When I talk about problems in regards to these two frequencies, I have to give you examples. If you have a patient that has a heart attack and no medic unit available, you don't have the capability of talking directly to a hospital that that medic unit has. You now have 20 units talking on one frequency that you need to get some vital information to. If lucky, if you start out with the patient, by the time you reach the hospital, you've gotten the information through to communications to relay to the hospital.

In relaying the communications from the ambulance to communications, more than half of that communications is lost by other units cutting in because they can't hear you trying to tell communications something.

If you are out of your unit and you only have that one fire portable, praying to God that it works, you run on a situation where you have to split your crew. You run up on the scene. You're going for one primary patient, and you find another patient. In between that, you get into trouble.

Hopefully, if the portable is working, the person that's in trouble has the portable. If he does not, your partner doesn't know what's happening to you, and you cannot get to your unit. This has happened.

We not only have the problems with the radios, we have the problems with the repairing of the radios and the repairing of the sirens, repairing of the apparatus. I will put all of that in the same category.

When you're talking about repairing ambulance radios and equipment, you're talking about down time. Everybody in this room today has talked about response time. You have no response time when you have numerous amounts of down time, because you can't get your radio fixed. You can't get your hose on your ambulance fixed. Your siren goes out; you've got to go down and change over to another piece.

Now, as they say, they have several units that are fully equipped now. At any given day in the summer in this city, you can have 10 units go out of service at one time just because of equipment failure due to heat, excessive abuse and use. You're still not including time for gas and time for persons that, by this job's classification, have injuries.

I've asked several times about—to the department about this job being classified as hazardous, and I am told over and over our job is not hazardous. Now I don't want to sound like I'm trying to beat on anybody's door, but I don't like a man sitting behind a desk tell-

ing me when I'm getting shot at out there on the street my job is not hazardous; and it has happened many times, not only to me but to other people out on the streets. We've had fire units on the scene with several ambulances when the ambulance was pinned down. Nobody knew where the crew was. Thank God they had enough sense to just fall under the ambulance and say, the heck with the situation, as long as I don't get killed.

They talk about low morale in regards to the ambulance service. Low morale comes from constant "you're an ambulance man; I am a firefighter. I dictate, and you obey." I know the system. That fire officer does not. However, he can tell me what to do after he asks this man what should he do.

The morale not only goes as far as morale on the street. We're talking about morale in training. A firefighter coming out of a fire academy has 1 year's probation. An EMT coming out of school has a year's probation and a 2-week OJT period. In that year's probation he is literally a second man on the street. He is not in an OJT training. He's not under close supervision other than by his partner after his second week.

They have said they are putting medics on fire units or EMT's on fire units. You cannot tell me, because I went to school, in my probationary year I come out of school, I can ride on this fire truck and say I'm now an EMT, when he hasn't even come out of his probation in firefighting. My people have to ride for an OJT period to just learn what's on the ambulance and what area they have to learn, and it takes more than 2 weeks to do all of that; but now they're telling me that a firefighter can come out of school after 2 weeks and say that this is the decision that I made, and this decision was right. At times he can ride with some of my people and say that he is the ACIC or the man in charge of that unit.

I ask you, how can that be?

In regards to training, the EMT's and paramedics in this city receive the highest training that I know of in this area. Paramedics are required to undergo a module training session before they become a paramedic. I've heard them talk about Baltimore and Virginia. I understand Virginia is now going to that 15 module standard.

Baltimore, compared to this city, is the same as an intermediate paramedic. Their paramedics don't come near what paramedics have to go through in this city. When we render care to the people in this city, we render it not as a job but as our lives, because this job is our lives.

Thank you, gentlemen. I will take your questions.

[The prepared statement of Mr. Fishburne follows:]

Before the Subcommittee on Fiscal Affairs & Health Committee on District of Columbia

Statement of Frank Fishburne, President, American Federation of Government Employees 3721, AFL- CIO

Mr. Chairman, Members of the Committee. I am Frank Fishburne, President of Local 3721. The local represents all Emergency Ambulance Bureau (EAB) employees, Apparatus Division employees, and the Automatic Data Processing and other Clerical Support Staff of the Division. We represent all those civilian employees who are direct service personnel. We do not represent the Dispatchers, who are represented by a fellow Local of the AFL-CIO, the Communications Workers of America.

I have with me today Jeffrey Goldstein and Calvin Haupt, members of the Local who have prepared this testimony. I thank you for your invitation to speak to this group today about the problems and concerns of the emp[loyees of the Emergency Ambulance bureau of the District of Columbia concerning the services we render to the public and the problems we face in rendering speedy and effective care to the citizens of the District.

Several months ago the attention of the city was focused on what the media called a crisis in the 911 Emergency System and the problems that surrounded the Emergency Ambulance Bureau (EAB) of the D.C. Fire Department.

This 'crisis' did not arise suddenly. It has existed for years and still continues today.

Precipitated by a number of exceedingly long response times and unprofessional handling of 911 calls, the city took a number of steps to address problems which were quickly perceived and endemic to our system. I would like to review with you today to the adequacy of these responses and the problems which still remain and must be addressed effectively and comprehensively in order for the EAB to effectuate its mission of providing pre-hospital emergency medical care to the public.

No longer can the Chief of the EAB be merely a step up the ladder for the fire officer, it is necessary to have experienced and skilled emergency medical services (EMS) administrators to take the EAB out of the ambulance era and into the modern EMS age. In response to this crying need, on May 5, 1987 City Administrator Thomas Downs said the city would hire a civilian director for the Bureau by the end of June. On June 30, 1987 a spokesman for the Mayor, Mr. John

White, said the city would hire a director within two weeks. These deadlines have come and gone and still no firm date has yet been set nor any apparent action taken to hire a civilian director instead only vague references to a decision being made within the "near future" are being promised by the city.

Meanwhile the Emergency Ambulance Bureau continues to function as it has in the past, due to the dedication and hard work of the E.M.T.'s and Paramedics who are working night and day to provide the best emergency medical care that they are allowed. But the problems that beset the Emergency Ambulance Bureau (EAB), problems that Local 3721 has been excluded from helping to solve, must begin at the highest levels of the EAB.

At the present time the Emergency Ambulance Bureau is run by Fire Officers with extensive experience in Fire Operations. But firefighting expertise is not adequate to operate the EAB. Would you have Police Officials controlling the Fire Department or EMS Managers operating the Police Department? Deputy Chief Fleming who was appointed to head the EAB after Deputy Chief McCaffrey was relieved found himself derided by his immediate subordinates and the press for bringing a single Battalion Chief into the EAB Headquarters to assist him during the transition period. Yet the current EAB Chief, Assistant Fire Chief Kilby has three Chiefs assigned to the EAB and several others assisting from positions outside the Bureau.

These fire personnel have delayed and derailed the steps Chief McCaffrey had taken to build a civilian infrastructure within the EAB. This lack of Emergency Medical Services experience is complicated by the fact that since 1974 there have been 14 different Chiefs in charge of the ambulance service. Chiefs who have received this assignment, that is, Chief of the Emergency Ambulance Service have utilized it as a prestigious stepping stone to a higher position in the Fire Department. It is difficult enough for the service to function without the complication of constantly shifting administrators, most of whom are just becoming familiar with the service when they are reassigned. We call attention to a recent story published in the Washington Times about a D.C. Fire "Position Paper on the Emergency Ambulance Bureau" written by Deputy Fire Chief Culver, the story describes how the main concern of certain elements in the Fire Department is to maintain control of the EAB and to turn the entire operation over to uniformed fire fighters. These are the actions of an agency which <u>not</u> committed to civilian management of the Bureau. Only professional EMS civilian managers can rid the Bureau of the political problems imposed by the Fire Departments control. This is a critical first step to overall improvement of the EAB.

At the present time 5 Medic Units and 16 Basic Life Support Ambulances provide the 650,000 residents with pre-hospital emergency care. Actually because of

business and tourist influx this population, utilizing the Fire Departments figures swells to 950,000. Last year this population generated 124,000 runs for the EAB. This year that figure will most probably exceed 130,000. This gives the District a call volume which is the highest per capita in the country. Because of this some EMS crews on an ambulance in the District are responding to 10 - 12 calls for assistance during a twelve hour shift. For a Medic Unit the typical day is now reaching between 12 - 15 responses. This burden is intolerable. A study done by Dr. Jeffrey Mitchell, an assistant professor of emergency health services at the University of Maryland shows that when a pre-hospital care provider exceeds 600 calls per year their stress levels become unhealthy and the individuals will "experience both physical and psychological symptoms". The average EMS crew in the EAB today is exceeding this limit by 300%. For some crews this figure is 400%.

Let me turn to equipment problems only, specifically communication. Currently the service operates with only one frequency for all communications with the ambulances. During the busy periods of the day it is difficult if not impossible to get on the air to talk to the dispatchers. There are times when a unit can leave a hospital after completing a response and make it all the way back to its quarters and have been unable to go in service because of the heavy volume of radio traffic. At this time for communication away from the ambulance we rely on portable radios that operate on the fire frequencies. Unfortunately this is complicated by several problems. First not all ambulance units have portable radios although each EMT should be equipped with a hand held portable radio capable of communicating with both Fire and Ambulance dispatchers. Second, Channel 4, which is the channel primarily designated for ambulance traffic has extremely short range and from most parts of the city it is impossible to transmit from inside a building. You can then attempt to use channel 1, which is the primary fire frequency but it is likely tied up with fire calls. Also the person you are talking to on the fire radio is across the room and does not have easy communications with the ambulance dispatcher further complicating the flow of information. In addition to these communications problems, the Medic Units have the problem of medical communications with the hospital. The medical radios we have now are extremely old and frequent breakdowns are commonplace. At the present, reliable communications with the hospital are only possible about 40% of the time.

Moreover, the ambulances are not all provided with mutual aid channels which are necessary in a metropolitan area over riding four jurisdictions including the Federal Government. In the event of a joint crisis effort such as the Air Florida crash a number of years ago the District EMS personnel could not talk to their colleagues from Virginia or Maryland, nor without relying on fire equipment can they talk to the helicopter handling drownings on the Potomac. The extreme irony in this is that part of the problem is created by management incompetence. Currently those portables which when purchased by the Fire Department include

the Mutual Aid Frequency have that channel removed by the radio shop. It is our understanding that the Department of Transportation has monies available for upgrading commuications elements in this as well as other areas. This avenue of funding should be explored as soon as possible by the Department.

With regard to the number of channels needed by the EAB, we recommend five. One channel for dispatching, a second channel as a information channel ie. for units to communicate with each other and with the EMS dispatcher, a third channel as a priority channel for unit to use only when it is in trouble, a fourth channel for communications with receiving hospitals, and a fifth channel as a tactical channel for the units to communicate with each other and EMS dispatchers while on Special Events, Security Details, or Crisis situations such as a hostage situation.

Many reports refer to the low morale and difficulty in hiring and retaining high quality personnel. We submit that these problems stem from the fact that the fire department has and is creating a self fulfilling prophesy, a situation where its EMS personnel are used as scapegoats for the errors of management and are made to feel as outsiders in there own system. In this system fire fighters are provided support, it is a system that holds out to those fire fighters who will work hard and study the opportunity to advance, but to the EMT's and Paramedics none of these things are available. The appointment of supervisory personnel has, except for one notable exception been haphazard at best, with few having formal management education, moreover within this same system all EAB policy is set by Fire Officers.

As a result training has suffered also. The District has for example, no training for a Mass Casualty Situation. While it has adopted the same system for the record that other COG jurisdictions have, it has not put in to place a continuous ongoing training for a Mas Casualty situation. Thus in thirteen years I have participated in only one such excersise. Most of our members have never participated in such an excersise.

Moreover, the Department has totally overlooked the reality of the need for on the job training for Fire Personnel assigned to the Bureau as EMT's. Because these Fire fighters have had fire duty experience they are exempt from the real on the job training that other EAB personnel must undergo. While we admire and respect the firefighters, experience in handling fires, this experience cannot substitute for caring for a patient who is intoxicated with PCP or other substances, a patient in Hypoglycemic Shock, or in Cardiac Arrest. There many firefighters who have received EMT training and have worked in overtime positions on EMS units, but never received the formal OJT experience on these same units. These same firefighters are serving as the EMT's on the Fire/Medical Units and are acting as the first responders for the EAB. This practise endangers the lives of the citizens

of the District and makes our job more difficult. It also builds resentment between firefighters and EMS personnel making morale deteriorate within our ranks.

You have asked that we specifically address the residency requirement. We think that either our wages must be dramatically increased or the residency requirement be abolished. Decent and affordable housing in the district is prohibitively expensive. It is unreasonable and unrealistic to have a residency requirement for EAB personnel. Many of the members of this bargaining unit have been contacted by individuals from other jurisdictions about the possibilities of working with the EAB. When they discover the residency requirement they go looking for another system in which to work. I know of one fellow worker who was unable to sell his house in Virgina for six months, because of this he could not move into the city to meet the residency requirement. We lost that individual when he was terminated. The residency requirement has been abolished for certain personnel such as nurses, physicians at D.C. General Hospital, computer personnel, and even some Department of Public Works personnel. It should be abolished for direct service personnel also. Finally, you asked that we address the issue of the refusal to transport. We decline to do so due to the complex nature of this issue. We do believe however that it is an issue that must be addressed comprehensively and with sensitivity. We request that this subcommittee promote the establishment of a task force within the Department to include senior EMT's, Paramedics and Medical Educators.

At the height of the medias interest in 911 operations the Mayor and several other City Officials met with representatives of Local 3721 and agreed to the implementation of 35 points of concern which the local had presented. But in the interim only a few of these concerns, which had already been in the process of being put into effect by the previous Chief of the EAB, have been instituted. Communication between the rank and file and management has bee to little and to late.

It is because of this and other concerns that brings us here today. There has been to much arguing among and between officials, departments, and to much finger pointing. It is time for the District to leave behind the era of ambulance service and step into the twentieth century of Emergency Medical Services, Local 3721 has committed itself to this goal we will continue to press forward with all its resources to see that the pre-hospital emergency medical services system of the District of Columbia develops into a system that we all can point to with pride and satisfaction.

I would be happy to take any questions.

Mr. FAUNTROY. I thank you, Mr. Fishburne and the entire panel. Your testimony, coming as it does from persons who are on the front line of this effort to deliver emergency services, has certainly been instructive for all of us.

You mentioned two areas of concern that have been raised a number of times during the course of this hearing. The first has to do with the availability of communications services for the emergency ambulance service, and it is your testimony that only one channel is available for use by the entire emergency service system, one of four that is available to the fire department. Is that what you're saying?

Mr. FISHBURNE. No. What I'm saying is, you have two separate entities here. On this side you have the fire side. They have four fire frequencies; have channel 1 which is their primary channel, channel 2 for their working fires, channel 3 is mutual-aid channel, channel 4 is what they use for special events. Right now, we're using it on the ambulance side.

On the ambulance itself there is only one frequency, and that one frequency is permanently mounted in that vehicle. It does not move with you like the fire radio does. Now at the present time we are using that fire radio on channel 4. However, if I'm in this room and I need to talk to that fire unit on the other side of this building, I'd be lucky if I can do it.

Mr. FAUNTROY. Has that problem surfaced as one of the concerns of the task force or the advisory committee that the Mayor established to assess the services delivery?

Mr. FISHBURNE. Yes, it has.

Mr. FAUNTROY. To your knowledge, is it among the 137 recommendations that Mr. Downs said were being implemented?

Ms. SPERLING. Yes.

Mr. FISHBURNE. I understand that it is; yes.

Mr. FAUNTROY. Does that mean it is your understanding that additional frequencies are being made available?

Mr. FISHBURNE. What was proposed—We met with Mr. Yeldell yesterday. What their proposal is is to add—buy new portables, fire portables, and give them to the ambulance. They're going to add repeaters to the ambulance so that, if I'm inside of a house and I need to get out on channel 4, I can do so.

Now I'm not sure if they're going to be moving that from the fire side to the ambulance side so I will have direct contact with my ambulance dispatcher. They also said in the long range they were getting—talking about the 800 Mhz radio.

Ms. SPERLING. Mr. Chairman, on that—On the channel 4 being utilized by the ambulance service, what they're going to do is they're going to remove it from the fire board to the ambulance board so they will now have access to two frequencies as opposed to one.

Mr. FAUNTROY. I see. All right. Both Ms. Rolark and others have—and you have testified to the need for good equipment, a variety of kinds; and, Mr. Fishburne, you mentioned that some equipment is inadequate because of both use and abuse. Is that what you said?

Mr. FISHBURNE. That's correct.

Mr. FAUNTROY. Give me an example of abuse of equipment.

Mr. FISHBURNE. You're talking about—Let's use the fire radios, for example.

Mr. FAUNTROY. The fire——

Mr. FISHBURNE. Fire radios, fire portable. You have a radio here that's been used for years by firefighters. This is at the present time what we have on the street. It's been banged around in a fire. It's been banged around in a fire truck. Now you're going to take that same portable, which a fire officer can barely use on fire ground, and give it to an ambulance.

Mr. FAUNTROY. That is the standard practice now?

Mr. FISHBURNE. That is the standard practice. Most of the portables—You have to understand, most of the portables on the ambulance don't work, haven't worked for years.

Mr. FAUNTROY. Say that again to me.

Mr. FISHBURNE. OK. Most of the portables on the ambulances don't work. I will give you an example of that.

Mr. FAUNTROY. Please give me an example. Give me an example of the emergency medical vehicle traveling around this city with a radio that doesn't work.

Mr. FISHBURNE. Give you an example of it?

Mr. FAUNTROY. Yes. Just give me——

Mr. FISHBURNE. My unit had a radio that could not transmit for over a year. I could hear fine, but if I needed to get some help, I'd better be able to get to that ambulance in a hurry. It ended up back in February that radio went into the shop. It stayed in the shop for 3 months.

In the process of it being in the shop, I had no portable radio. I went for an OB call. My partner went inside to take care of the OB. I found a gentleman laying on the sidewalk that I thought was an overdose. I could not get back to my unit. I could not contact my partner. In the process, I got shot at by a 357 seven times. That happened——

Mr. PARRIS. Would you like another example, Mr. Chairman?

Mr. FAUNTROY. I'm reeling from this one.

Ms. SPERLING. Mr. Chairman, from a communications standpoint, that's the way it goes. The portables do not work. The dispatcher can tell that somebody is keying up. You might get a designation as to who is calling, but the rest is just like static; or there's this radio channel that comes in, and you can hear the radio channel, but you can't hear the ambulance people. This is on the ambulance frequency, not channel 4.

It's like downstairs—The radio repair shop is a part of the communications division. They are the repair section of the communications division, and they have baskets and baskets of portable radios that are in various stages of disrepair. They don't work on them.

There were two instances where the ambulance frequency, the only means that we have to contact ambulances, went out 2 days in a row, and the radio repair—The answer that we got was that we don't have the equipment to repair it. So we had to take a medic unit and place them out of service to relay the ambulance's information on the street—Well, the assistant fire chief of EAB said put the medic unit back in service.

So I was detailed on one of those occasions to go down to apparatus, pick up a reserve unit and take it and ride the street to relay information, because communications couldn't. They could hear, but they couldn't transmit.

Mr. FISHBURNE. I can give you several more.

Mr. FAUNTROY. Have you shared this with the duly elected members of the legislature of the District of Columbia, one?

Ms. SPERLING. Yes.

Mr. FAUNTROY. And have you—Explain to me how, when a team comes in and says to the supervisor, we have a communications instrument on our ambulance that does not function——

Mr. FISHBURNE. Sir, you don't need to tell them that. They already know it.

Ms. SPERLING. They know it.

Mr. FAUNTROY. If that person knows, and it seems to me that communication is essential to your doing the job and the mission that you have to accomplish, how can a radio transmitter stay in disrepair for 1 year on anybody's ambulance?

Mr. FISHBURNE. Well, my answer to that is management feels that the only functioning radio that you really need is the main radio at communications, and that main radio in the unit. By any means, you should be able to escape whatever is happening and call for help by your radio. That's the only thing that I can see.

In all of the years that I have been there, I cannot really say that anyone on the ambulance has had any type of protection to say here is how you help yourself.

Ms. SPERLING. Mr. Chairman, I disagree with what Mr. Fishburne just said. They don't even care that the equipment is not working in communications. We can't get our equipment fixed. Our equipment is not important. When we report malfunctioning or nonworking equipment, we're told that it's not an equipment problem, it's an operator problem.

We use the vocals to dispatch ambulances from quarters, fire trucks from quarters. It's gone out on three occasions that I know, where you couldn't—You had to call firehouses via telephone, because you couldn't get out over the vocal.

It went out on my crew like on a Friday night. We put in a trouble ticket. It was Tuesday before the fire department decided that it needed to be fixed.

Mr. FAUNTROY. I see. My time has expired.

Mr. PARRIS. Aren't you glad?

Mr. FAUNTROY. I want to yield to the gentleman from Virginia.

Mr. PARRIS. Thank you, Mr. Chairman. While we're having so much fun with portable radios, let me refer to your comments, Mr. Fishburne, on page 3 of your testimony in which you say that in the situation of the Air Florida crash of a few years ago, and in the problem of communications generally, helicopter drownings in the Potomac and other things, the irony of this situation, in your statement, is that it's created by management incompetence.

Now you say that the portables, the portable radios, purchased by the fire department include, as a matter of normal function of an emergency equipment, a so-called mutual-aid frequency. This lets you talk to the people in Virginia and Maryland, and that's

what that's all about—Right? That the management of your emergency service has that channel removed by the radio shop—Why?

Mr. FISHBURNE. I don't have any idea, sir.

Mr. PARRIS. Has anybody ever ask them?

Mr. FISHBURNE. Let me put it to you this way. The channel is only removed from the ambulance frequency. On the fire frequencies, there is a mutual aid; but, however, in all instances you don't have a fire unit there.

Mr. PARRIS. Isn't this another great example of the lack of priority of the emergency medical service? I will recall—I don't mean to be melodramatic about this, but I remember standing on a bridge when the Air Florida crash occurred and having the ambulance people who were dragging frozen people out of the Potomac, talking to the fireman who was yelling at the fire truck to talk to the other ambulance. Now that's absurd.

Mr. FISHBURNE. I have to agree with that.

Mr. PARRIS. And that was 5 years ago? Perhaps more?

Mr. FISHBURNE. Yes.

Mr. PARRIS. Mr. Chairman, I know that you are as shocked, if you will, by some of the information we received today as I am. I'm sure, and I've said this before and I mean it, there is a common purpose for all of us here, and that's to improve the system, the services, the capacity that we have to deal with these problems which are so critical.

I think—I hope, Mr. Chairman—I'm sure that you now understand why some of us are so enthusiastic about having an opportunity to air some of these problems, not for the purpose of being critical or argumentative but to try to help correct some of these things which are simply criminal, to the extent that they exist and or the periods that they go on.

Let me, with all that, just ask a couple of quick questions here. It's been a long day. It's only half over on the floor.

Let's talk about radios just another few moments, Mr. Fishburne. You perhaps heard, and we are informed—Mr. Downs testified that there is a brand new radio system being obtained by the District of Columbia, a 800 Mhz truncated radio system, the latest in technology, et cetera. Are you familiar with that?

Mr. FISHBURNE. Yes.

Mr. PARRIS. And that was purchased. It has been purchased, has it not?

Mr. FISHBURNE. I was informed that it has been purchased, yes.

Mr. PARRIS. If I told you it was sitting in the middle of the floor in a fire house unused because the city did not have the antennas, would that surprise you?

Mr. FISHBURNE. No.

Mr. PARRIS. That's true, isn't it?

Mr. FISHBURNE. As a matter of fact, they found out that the console that they had sitting in the middle of the floor was the wrong console. Now they have to send for another console.

Mr. PARRIS. It's been sitting there for months, hasn't it?

Mr. FISHBURNE. That's correct.

Ms. SPERLING. Yes.

Mr. FISHBURNE. Now we have also—While you are on that subject, we have asked for five frequencies on that particular radio; and if you would like, we can go into what and why.

Mr. PARRIS. Oh, I understand it, and some of that is covered in your testimony, Mr. Fishburne. Suffice it to say, if you might—and I don't mean to cut you off in any way—but suffice it to say that, as I understand it, the last of the channels is indeed a fire channel and, if it's being operated by the fire department for some purpose, you can't bust through that signal in any event.

So that extra channel that's been allotted to you in some way is unusable, in any event. Is that correct?

Mr. FISHBURNE. Well, I can't say it's unusable, because I have no idea——

Mr. PARRIS. Not totally usable, is it? Let's put it that way.

Mr. FISHBURNE. Right. Right.

Mr. PARRIS. Let me ask you, any one of you ladies and gentlemen—I don't mean to concentrate here on Mr. Fishburne. How big is the problem of people calling ambulance service that is a non-emergency? Is that a major percentage of your problem? Yes, ma'am?

Ms. SPERLING. As a dispatcher, that's our major problem. We transport anything from a clinic appointment to——

Mr. PARRIS. These are just people who want medical treatment, just normal sick people. I got a stomach ache. Right?

Ms. SPERLING. We send for stomach aches——

Mr. PARRIS. Or if I just have an appointment?

Ms. SPERLING. If you have a clinic appointment.

Mr. PARRIS. You send an ambulance, pick me up, take me——

Ms. SPERLING. Yes. We are not allowed to refuse anything.

Mr. PARRIS. What can we do about that?

Ms. SPERLING. Well——

Mr. PARRIS. What can we do about that?

Ms. SPERLING [continuing]. Earlier this year we—the fire department had this committee including Ms. Moreau and Ms. Adams and some dispatchers and paramedics and EMTs. We went through the priority dispatching system to try and make it more palatable so that the dispatchers would not have to diagnose over the phone, which is what we do from the old system.

I don't know where that—the changes that we made are at this time, but I know none of them have been implemented in communications. We were never—Ms. Moreau and Ms. Adams did try to help us when they first implemented the priority dispatch system. They did try to teach us how to handle it; but we had no true formal training on the priority dispatching. To this day, there is no training for new dispatchers.

True enough, the city has hired the 45 people, but they are just 15 bodies. They did one week of riding fire and medical apparatus. They did 1 week of inhouse introduction to the fire service, and that has been the extent of their training, other than the training the senior dispatchers can give them between calls, which is practically nil and void; because our workload is such that we don't have time to really sit and train them, because we have our work to do. There is no training program.

Mr. PARRIS. And for many periods of the time when you are working and there's a trainee sitting at your elbow, you don't have time literally to talk to that individual for 12 hours in a row. Right?

Ms. SPERLING. That's true. I have four trainees.

Mr. PARRIS. And that—Four?

Ms. SPERLING. Four.

Mr. PARRIS. That hardly constitutes an effective training program, in my point of view.

Ms. SPERLING. That's true. I had five, but one requested a shift change, and they changed his crew. So now I have four trainees, and I haven't really had a chance to work with them, because we've been so busy and so understaffed.

Mr. PARRIS. Over what period of time?

Ms. SPERLING. I've had one trainee for a month, one for 3 weeks, and one—and the other two for 2 weeks.

Mr. PARRIS. Mr. Chairman, let me just make a statement that I regret, and that's not what this hearing is all about; but I regret that the members of the press, as it seems to me they so often do, have come and gone in what I think we are receiving from these ladies and gentlemen who are involved on a daily basis with this problem. The members of the press were here when we were engaging, in my opinion, in rhetorical dancing by Mr. Downs who has very little, if any, practical knowledge of what's happening in the real world in his emergency medical service.

I regret that for those kinds of reasons that we may sometimes get a distorted view of what the real world is all about in some of these things.

Let me just quickly cover a couple of other aspects. You have no right to refuse—and no authority to refuse transport to anybody, regardless of what?

Ms. SPERLING. Regardless of anything. We—Under the priority dispatch system and city rules and regulations, we cannot refuse service to anybody. I've taken numerous calls where they will call in, they'll say, so and so is in my house and I want you to come and get him and take him to the hospital. You'll say, well, what's the problem? They'll say, well, he's drunk and I want him out of my house. We have to send an ambulance.

We can't take that address and call the police and say, hey, police, we have a detox for you at such and such address or an unruly citizen. We have to send an ambulance.

Mr. PARRIS. Isn't it also true when that ambulance gets to that location and finds that individual, they have to transport?

Ms. SPERLING. Sure.

Mr. PARRIS. Does the priority dispatch system work, in your opinion?

Ms. SPERLING. No.

Mr. PARRIS. But that's the system under which you're working. Right?

Ms. SPERLING. True, but, see, before the priority dispatch system even went into effect, the citizens on the street knew about it, and they knew all the key words to use. If they say those key words, you have no other avenue to take other than to send engine company, medic unit, and a basic unit; and they know the key words.

Therefore, a lot of times the true emergencies fall through the cracks, because they're tied up on something that's not even an emergency.

Mr. PARRIS. Finally, Mr. Chairman, let me quote from the last page—I think it's 4—of Mr. Fishburne's prepared testimony, in which he says: "The residency requirement must"—and I'm including that word, because I'm paraphrasing—"residency requirement must be abolished." Do you agree with that statement—still continue to agree with it, Mr. Fishburne? It's your statement. I assume you stand behind it?

Mr. FISHBURNE. Yes.

Mr. PARRIS. You go on to say that many members of the bargaining unit, the union association that you all represent, have been contacted by individuals from their jurisdictions about the possibilities of working with the emergency ambulance bureau. When they discover the residency requirement, they go looking for another system in which to work.

Mr. FISHBURNE. That's correct.

Mr. PARRIS. Is that happening today? It happens frequently, does it not?

Mr. FISHBURNE. That happens every day. My most recent involvement with that was two people from North Carolina who are paramedics in North Carolina, were inquiring about getting a job here in the city; and they in fact had already put applications in. When they found out about the residency requirement, they said, you mean I've got to sell my house in North Carolina and live here permanently? I said, yes.

Said, well, if I sell my house in North Carolina, am I going to be able to afford a house here? I said, that depends.

Mr. PARRIS. The answer is no.

Mr. FISHBURNE. I said, do you want to live in a log cabin or do you want to live in a house? That was my answer to them.

Mr. PARRIS. You go on to cite in your testimony, and I think—there's no desire on my part to use names, and please don't. I don't think it's important. But I think I was involved, because this gentleman that I believe you refer to was a constituent of mine from northern Virginia. He was hired by the District. He had 6 months in which to comply with the residency requirement. He had a house in northern Virginia, put it on the market, couldn't sell it. They terminated him, because he didn't move into the District within the 6-month period.

Mr. FISHBURNE. That's correct.

Mr. PARRIS. He's a qualified emergency medical technician. They fired him. That happens, too, doesn't it?

Mr. FISHBURNE. That's correct. That does happen.

Mr. PARRIS. That situation that you allude to, I'll bet you—not important. I'll bet you it's the same guy, and he's not the only guy or the only lady, the only person. This happens all the time.

Mr. FISHBURNE. It happens every day.

Mr. PARRIS. My last question to you ladies and gentlemen is: Does anybody ever try to justify that to you? What do they say when you ask them? We don't have enough people here. We can't get good trained people to work here? We need them badly. What do they tell you when you say that?

Mr. HAUPT. Well, first let me respond to that. My name is Cal Haupt. When you look at our service alone and you look at the residency requirement, I think what we should do is expand it to the safety cluster as a whole, the police department, the fire department and EAB.

Mr. Fauntroy is probably aware of it, but in 1990 we're going to have a crisis called the 20-year crisis in which half the police department, half the fire department can retire; and we're going to have a hiring problem, a massive hiring problem.

We're employees. Most of us live in the city, and we're concerned about that; because we want to protect our loved ones there in the city. So we're trying to make an effort to get everybody to be aware of the fact that we need to recruit qualified people to protect our populous.

A lot of us do this job not because of the money. A lot of us do it because, just like yourself, we have a desire to give the public back something that they may have given you. OK?

What do you tell them when? What do you tell people who try to come to the District of Columbia to work? I discourage a lot of people that I know would have been great for the city, because I cannot in good conscience have them come in the city and create a problem for their loved ones and know it's on my conscience that I did that.

Mr. PARRIS. Well, you've made an important statement, Mr. Haupt, because, very frankly, we are all—when you look down the road just a couple of years now, I've got something like 13-1,500 grandfathered employees who are constituents of mine who, very shortly now—This residency program has been in effect for 6 or 7 years.

Mr. HAUPT. Yes, sir.

Mr. PARRIS. Very shortly now, those people, all 1,300 of them, more or less, are going to be running up against retirement age, and they're all going to retire.

Mr. HAUPT. Oh, yeah, all of them.

Mr. PARRIS. All of the grandfathered ones. Now you tell me, when you get vacancies right now in the qualified service, trained personnel, where are you going to find 1,300 more 2 years from now?

Mr. HAUPT. Mr. Parris, I think what you are going to find is that when 1990 comes the city is going to be in the middle of a new concept. I think they're going to find out that there is an Achilles heel that they're going to pay for. They could have avoided it, but they're going to pay for it.

Mr. PARRIS. Well, I'll say it one more time. We came within 10 votes of doing it within the last 30 days, and I'm going to keep doing it. I say to my friend from the District of Columbia, this is not the last time. You're going to hear about residency from me, and I hope from these ladies and gentlemen and the organizations which they represent. Time for that action is long since past. I thank the Chairman.

Mr. FAUNTROY. I thank the gentleman. The time for closing of this hearing is long since past and, while I want to—I must conclude the hearing at this point, let me commend the panel for their testimony. I would wish that, in addition to the press being here,

more important that those who testified earlier could have been here so that we could question them on the facts which have been brought to our attention here; and you have not heard the last from me in terms of a sitdown between the four of you and some people I know.

Thank you.

[Whereupon, at 4:09 p.m., the subcommittee was adjourned.]

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